85-632

Supreme Court, U.S.
FILED
OCT 11 1985
JOSEPH F. SPANIOL, JR.
CLERK

No. 85-

IN THE
SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1985

CHARLES ATKINS, Commissioner
of the Massachusetts
Department of Public Welfare,

Petitioner,

v.

SANTOS RIVERA, Madeline McKenna,
and all others similarly situated,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME JUDICIAL COURT FOR THE COMMONWEALTH OF MASSACHUSETTS

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QUESTION PRESENTED

Does a six-month spenddown period for medically needy Medicaid eligibility, which has been permitted by federal regulation since 1966, is employed by most states which extend coverage to the medically needy, allocates resources to the most needy of potentially eligible applicants, and has very recently been upheld by the First and Second Circuits, violate Title XIX of the Social Security Act?

PARTIES

The respondent class is composed of all AFDC-related medically needy applicants for or recipients of Medicaid in Massachusetts subject to a six-month spenddown. All other parties are named in the caption.

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PETITION FOR A WRIT OF CERTIORARI
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Charles Atkins, Massachusetts Commissioner of Public Welfare, respectfully petitions for a writ of certiorari to review the opinion and order of the Massachusetts Supreme Judicial Court.

OPINIONS BELOW

The opinion of the Supreme Judicial Court (A1) is reported at 395 Mass. 189 and 479 N.E.2d 639. Rehearing was denied without opinion. A63. The opinion of the Hampden Superior Court (A28) and the administrative decisions of the state Department of Public Welfare (A46, A54) are not reported.

JURISDICTION

The opinion and order of the Supreme Judicial Court, the highest court of the Commonwealth of Massachusetts, were entered on June 12, 1985. On August 21, 1985, Justice Brennan extended the time in which to petition for certiorari, to and including October 15, 1985 (Supreme Court docket no. A-147); this petition is being filed on or before that date. In addition, the Commissioner's petition

for rehearing in the Supreme Judicial Court was denied on September 26, 1985 (A63); this petition for certiorari is being filed within 90 days after that date. The jurisdiction of this Court is invoked under 28 U.S.C. § 1257(3).

STATUTES INVOLVED

This case involves the construction of 42 U.S.C. § 1396a(a)(10)(C)(i)(III) (1982), which provides that a State choosing to extend Medicaid coverage to medically needy groups must, in its state plan, describe:

> (III) the single standard to be employed in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligibility, which shall be the same methodology which would be employed under the supplemental security income program in the case of

> groups consisting of aged, blind, or disabled individuals in a State in which such program is in effect, and which shall be the same methodology which would be employed under the appropriate State plan (described in subparagraph (A)(i)) to which such group is most closely categorically related in the case of other groups; . . . (emphasis added)

The decision below held that the emphasized language requires a one-month spenddown in determining medically needy Medicaid eligibility, and on that ground held invalid Mass. Gen. Laws ch. 118E, § 10 (fourth unnumbered paragraph) (1984 ed.), which provides:

> In any case where the monthly income of a recipient or beneficiary is in excess of the exemptions allowed, the recipient or beneficiary shall be liable to pay to the provider of medical care or service an amount which shall be equal to the excess income for a period of six consecutive months, which includes the period when such service was provided. (emphasis added)

The spenddown concept derives from 42 U.S.C. § 1396a(a)(17), which provides that the state Medicaid plan must:

> include reasonable standards . . . for determining eligibility . . . ; and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums or otherwise) incurred for medical care or for any other type of remedial care recognized under State law[.] (emphasis added)

42 C.F.R. § 435.831 (1984) provides:

> The [state Medicaid] agency must determine income eligibility of medically needy individuals in accordance with this section. The agency must use a prospective period of not more than 6 months to compute income. . . .

STATEMENT OF THE CASE

Statement of Facts

This case presents a pure question of statutory construction, which the

Massachusetts Supreme Judicial Court resolved in a manner and with a result directly contrary to recent decisions of the First and Second Circuits.[1/] The important facts concern the structure and operation of the statutes involved.

Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 et seq., was enacted in 1965 to enable states, "as far as practicable under the conditions in such State," to provide medical assistance ("Medicaid") to needy families and to aged, blind or disabled individuals. 42 U.S.C. § 1396. Participating states must provide coverage to all those who receive cash assistance under either of the major federal categorical welfare programs:

1/ Hogan v. Heckler, 769 F.2d 886 (1st Cir. 1985); DeJesus v. Perales, 770 F.2d 316 (2d Cir. 1985).

Aid to Families with Dependent Children (AFDC), 42 U.S.C. §§ 601 et seq., and Supplemental Security Income (SSI), 42 U.S.C. §§ 1381 et seq. See 42 U.S.C. § 1396a(a)(10)(A). These groups are referred to as the "categorically needy."[2/]

Massachusetts has chosen to extend coverage as well to the "medically needy" -- families and individuals who would qualify for AFDC or SSI, but for their income or resources. Those who meet the categorical (but not the financial) requirements for AFDC, including the members of the respondent class in this case, are known as the "AFDC-related medically needy." The respondents do not

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2/ Eligibility for the categorical programs of cash assistance is determined on a monthly basis. See 42 U.S.C. § 602(a)(13) (AFDC); 42 U.S.C. § 1382c(1) (SSI).

qualify automatically for Medicaid, however, because their net countable income exceeds the medically needy income level. The determination of their Medicaid eligibility involves an extra factor, not considered for categorically needy eligibility: they may become eligible if they incur medical bills equal to their excess income. The amount of medical bills that must be incurred prior to attaining eligibility is known as a "spenddown."

Mass. Gen. Laws ch. 118E, § 10 (fourth unnumbered paragraph)[3/] requires the calculation of excess income over a six-month period to arrive at the spenddown amount. Once the applicant incurs medical bills equal to the amount

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3/ See also the state implementing regulations, noted at A9 and quoted in Hogan v. Heckler, supra, 769 F.2d at 889 n. 5.

of the spenddown, Medicaid pays for all other covered services during the six-month period.[4/]

The Secretary of Health and Human Services, and before her the Secretary of Health, Education and Welfare, has permitted a spenddown period of up to six months since the inception of the Medicaid program in 1966. DeJesus v. Perales, 770 F.2d 316, 332-23 and n. 8 (2d Cir. 1985); Hogan v. Heckler, 769 F.2d 886, 893 (1st Cir. 1985). In reliance upon the Secretary's regulations, 25 of the 32 jurisdictions participating in the medically needy program use a spenddown period of greater than one

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4/ This statutory context is described more fully in Hogan v. Heckler, supra, 769 F.2d at 887-89; see also Schweiker v. Hogan, 457 U.S. 569, 571-76 (1982); DeJesus v. Perales, supra, 770 F.2d at 318-19.

month; most, like Massachusetts, use six months.[5/]

Prior Proceedings

The action was brought in May 1983 in the Massachusetts Superior Court against the Massachusetts Commissioner of Public Welfare ("Commissioner"), as a class action challenging the state's use of a six-month spenddown as violative of Title XIX.[6/] The trial court certified

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5/ These figures are derived from interrogatory answers filed by HHS in October 1983 in Hogan v. Heckler and submitted at the summary judgment stage below. See Record Appendix in the Supreme Judicial Court, at 152-168.

6/ The complaint claimed that: "Defendant's policy and practice of using a six-month period for calculating the income of AFDC-related medically needy applicants for and recipients of Medicaid violates 42 U.S.C. § 1396a(a)(10)-(C)(i)(III) . . .." Complaint, ¶ 31.

(footnote continued)

a plaintiff class of AFDC-related medically needy applicants for or recipients of Medicaid subject to a six-month spenddown and found, on cross-motions for summary judgment, that the six-month spenddown violated the "same methodology" requirement of § 1396a(a)(10)(C)(i)(III), because AFDC eligibility is calculated on a monthly basis. The lower state court ruled that Mass. Gen. Laws ch. 118E, § 10, in requiring a six-month spenddown, is "in direct conflict with federal law" and "must be voided pursuant

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(footnote continued)

The complaint also charged that the six-month spenddown violated 42 U.S.C. § 1396a(a)(17). Judge Friendly saw "little force" to this contention in DeJesus v. Perales, 770 F.2d 316, 323 (2d Cir. 1985); it also was rejected in Hogan v. Heckler, 769 F.2d 886, 891 et seq. (1st Cir. 1985). The courts below did not address the argument.

to the Supremacy Clause of the United States Constitution." A42.[7/]

On appeal, the Supreme Judicial Court affirmed.[8/] After considerable attention to another issue,[9/] that court addressed and invalidated the six-month

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7/ The Amended Judgment, entered in the Superior Court on May 24, 1984, declared that provision of § 10 to be void pursuant to the Supremacy Clause and permanently enjoined the use of a spenddown period of longer than one month. A66 (¶ 4), A67 (¶ 6).

8/ The Commissioner preserved this issue as the principal question presented on the appeal, phrased as follows: "Is the six-month Medicaid income spenddown provision of G.L. c. 118E, § 10, invalid under federal law, notwithstanding the interpretation of the Secretary of Health and Human Services that a six month spenddown is consistent with federal law?" Brief for Appellant in the Supreme Judicial Court, at 1.

9/ Whether the failure to deduct payroll withholdings from earned income in calculating Medicaid eligibility violated state law -- the court found that it did not. See A61; A10-A23.

spenddown in two paragraphs. A23-26. Essentially, the state's highest appellate court relied upon the analysis of Hogan v. Heckler, 597 F. Supp. 1106 (D. Mass. 1984), a federal trial court decision which has now been reversed by Hogan v. Heckler, 769 F.2d 886 (1st Cir. 1985). The court reasoned that "the length of the spenddown period is part of the methodology for evaluating income eligibility," A24 (quoting 597 F. Supp. at 1110), and that the use of a six-month spenddown for medically needy eligibility is more restrictive than the one-month budget period used for the categorically needy, and therefore invalid. A25-26. The court "affirm[ed] that portion of the [Superior Court] judgment which determined that the department's use of a six-month budget period for spenddown

purposes violated 42 U.S.C. § 1396a(a)-(10)(C)(i)(III)." A26-27. The rescript so ordering entered on June 12, 1985. A61.

On August 12, 1985, Hogan v. Heckler, 769 F.2d 886 (1st Cir. 1985), and DeJesus v. Perales, 770 F.2d 316 (2d Cir. 1985), were decided -- both in direct conflict with the decision below. In order to bring these intervening authorities to the attention of the Supreme Judicial Court prior to seeking review in this Court, the Commissioner sought an extension of time until October 15, 1985, in which to petition for certiorari, No. A-147, which was allowed on August 21, 1985, and filed a petition for rehearing, which the Supreme Judicial Court denied without opinion on September 26, 1985. A63.

REASONS FOR GRANTING THE WRIT

I. THE DECISION BELOW DIRECTLY CONFLICTS WITH RECENT DECISIONS OF THE COURTS OF APPEALS FOR THE FIRST AND SECOND CIRCUITS; THE CONFLICT EXTENDS TO CONTRARY HOLDINGS AS TO THE VALIDITY OF A SPECIFIC MASSACHUSETTS STATUTE.

The decision below is in direct conflict with Hogan v. Heckler, 769 F.2d 886 (1st Cir., August 12, 1985) (opinion by Campbell, C.J.) and DeJesus v. Perales, 770 F.2d 316 (2d Cir., August 12, 1985) (opinion by Friendly, J.), both of which expressly rejected its interpretation of Title XIX. 770 F.2d at 327-28; 769 F.2d at 898, 891 n. 11.

In Hogan v. Heckler, the First Circuit held that Mass. Gen. Laws ch. 118E, § 10 (fourth unnumbered paragraph), is consistent with 42 U.S.C. § 1396a(a)(10)-(C)(i)(III) and therefore is valid. In

the decision below, the highest court of the Commonwealth held that the same state statute is not consistent with § 1396a(a)(10)(C)(i)(III) and therefore is void. These holdings rest entirely upon a conflicting interpretation of Title XIX; no state law grounds are involved. The only difference between the two cases is that the plaintiff class in Hogan consists of "SSI-related" medically needy applicants or recipients subject to a six-month spenddown, while the respondent class herein consists of "AFDC-related" such individuals. As the court below expressly recognized, the legal analysis is unaffected by this difference. A24-A25.

In DeJesus v. Perales, the Second Circuit specifically held, also contrary to the decision below, that a six-month

spenddown is consistent with § 1396a(a)(10)(C)(i)(III). DeJesus, like the decision below, involved a class of AFDC-related applicants and recipients. The only difference between DeJesus and this case is geographical.

This conflict over the construction of a federal statute between two federal courts of appeals on the one hand and the highest court of a state on the other is by itself sufficient to warrant review on certiorari. But there is an extra, pressing dimension to this petition because two of these contrary holdings create a conflict within Massachusetts itself.

Hogan v. Heckler declares the six-month spenddown required by Mass. Gen. Laws Ch. 118E, § 10, to be valid; the decision below holds it to be void. The petitioner is placed in a dilemma by

these rulings. It is his duty to enforce the Massachusetts statute unless it is invalid. The federal court of appeals, in a thorough and persuasive opinion, has determined that the statute is valid under federal law; but the state court has declared otherwise. The petitioner has attempted to persuade the court below to reconsider on the basis of the intervening decisions of the federal courts of appeals, but that effort was inexplicably rejected. Unless review is granted by this Court, the petitioner will remain enjoined, on the basis of Title XIX, from enforcing a state law which the First Circuit has determined to be consistent with Title XIX.10/

10/ This anomoly could well be exacerbated in future proceedings. The Hogan

(footnote continued)

There are no distinguishing features between Hogan, DeJesus and this case. The First and Second Circuits, in comprehensive and well-reasoned analyses by Chief Judge Campbell and by Judge Friendly, respectively, held that Title XIX does not require a one-month spend-down; the decision below, in two para-

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(footnote continued)

plaintiffs have already taken the position that 42 U.S.C. § 1396a(a)(17), which provides that eligibility standards must be "comparable for all groups," see 770 F.2d at 891, 894, requires the same spenddown period for SSI-related as for AFDC-related medically needy. See 769 F.2d at 891, n. 11. The First Circuit could well hold that six months is permissible for both groups, while the Supreme Judicial Court seems likely to adhere to the view that as a matter of federal law one month is required for both, with the Commissioner caught in the middle. Review by this Court at this time would forestall such a confrontation.

graphs, took a contrary position.[11/] The conflict could not be more real, direct, or immediate; the need for its resolution by this Court is serious and pressing.

11/ While these are the only appellate courts to have addressed this issue, it is an issue of national significance and has been the subject of at least the following district court actions: Allen v. Petit, No. 85-0025-P (D. Me. June 3, 1985) (invalidating six-month spenddown for both AFDC-related and SSI-related medically needy); Cashman v. Perales, No. Civ 85-0639-T (W.D.N.Y. Aug. 29, 1985) (upholding six-month spenddown for SSI-related medically needy); Coleman v. Miller, No. 82-C-6259 (N.D. Ill., Feb. 23, 1984) (invalidating six-month spenddown for AFDC-related medically needy); Hodges v. District of Columbia, No. 85-1616 (U.S.D.C., D. D.C.) (filed May 17, 1985; cross-motions for summary judgment pending); see also Brogan v. Miller, 537 F. Supp. 139 (N.D. Ill. 1982) (invalidating six-month spenddown for SSI-related medically needy in "§ 209(b) option" state).

II. THE DECISION BELOW RAISES AN IMPORTANT QUESTION CONCERNING THE PROPER INTERPRETATION OF TITLE XIX, WHICH SHOULD BE SETTLED BY THIS COURT.

The ruling below raises a federal question of undeniable importance. The medically needy program is a very significant component of Medicaid,[12/] and the length of the spenddown period fundamentally affects its scope, and therefore its cost and the allocation of resources within Medicaid generally.

Twenty-nine states, Puerto Rico, the Virgin Islands and the District of Columbia participate in the medically needy program. Of these, 25 (24 states and the District of Columbia) use spenddown

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12/ In Massachusetts, 53.3% of Medicaid expenditures in fiscal year 1985 went to the medically needy (without a one-month spenddown).

periods of greater than one month.[13/]

The impact of the imposition of a one-month spenddown upon these jurisdictions would be substantial. The Commissioner estimated in 1983 that the increased payments resulting from a one-month spenddown for the AFDC-related medically needy in Massachusetts (a program which expended $47.8 million in fiscal year 1983) would be $19.6 million in the first year, with the potential for a substantially greater increase thereafter.[14/] In Hogan v. Heckler, the Commissioner projected that additional

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13/ Fifteen states and the District of Columbia use a six-month period; five states use three months; four use a combination of six and either one or three months. See n. 5, supra.

14/ See Record Appendix in the Supreme Judicial Court, at 186 (¶ 12), 184 (¶ 4(e)).

payments resulting from a one-month spenddown for the SSI-related medically needy program in Massachusetts (which expended $570 million in fiscal year 1985) would be in the range of $208 million annually.15/ These projected costs in Massachusetts of the increased coverage resulting from a one-month spenddown total approximately 20% of the state's fiscal year 1985 Medicaid budget of $1.168 billion. Although these are only roughlyestimated projections, they give some idea of the magnitude of the impact of the decision below. This magnitude is corroborated by the figures presented for New York. DeJesus, supra,

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15/ The SSI-related group has considerably greater medical costs since it is composed of elderly and disabled individuals.

770 F.2d at 320 ($78 million annually, for inpatient hospital care only).

States such as Massachusetts use a six-month spenddown as a method of allocating scarce welfare resources. The use of a spenddown period of six months, rather than a shorter period, focuses the State's allocation of resources upon the most medically needy. For example, an applicant whose "excess income" (net countable income in excess of the Medicaid standard) is $100/month and whose medical expenses exceed $600 over a six-month period is more needy than another applicant with the same income but with medical expenses of only $300 over six months -- even if the entire $300 happens to be incurred all in one month. While limiting its medically needy coverage to the former group, Massachusetts uses a

high standard of income eligibility and provides a wide range of covered services to those found eligible.

Whether Congress intended to impose upon Massachusetts and 24 other jurisdictions a one-month spenddown, which would require a fundamental reallocation of resources (e.g., by withdrawing from the medically needy program, by providing a narrower range of covered services, or by lowering the standard of income eligibility) is intrinsically an important federal question warranting review by this Court.

The question is important not only to the States which will have to reassess their participation in the medically needy program or substantially reallocate their resources. It is of "great concern" to the respondent class members, and to those similarly situated in other

states, whose Medicaid eligibility is at issue. DeJesus, supra, 770 F.2d at 318. It is of considerable potential importance as well to those individuals who are or will be eligible for Medicaid under the current allocation of resources, but whose eligibility, or the scope of whose benefits, may be adversely affected by the restructuring of Medicaid programs which the imposition of a one-month spenddown predictably would entail. Finally, it is of great significance to Congress, which clearly had no intention to require such a result.

The "same methodology" language of 42 U.S.C. § 1396a(a)(10)(C)(i)(III) was enacted in the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA"), P.L. 97-248, § 137(b)(8), 96 Stat. 324, 378, as a "Technical Correction[] from Omnibus Budget Reconciliation Act of

1981," see 96 Stat. 376. There is no hint in the legislative history that either the purpose or the effect of this technical correction was to force 24 states and the District of Columbia to substantially expand the scope of their medically needy programs by requiring a one-month spenddown.

This language inserted by TEFRA simply cannot be applied literally to the spenddown calculation. The concept of offsetting medical expenses against income is the creation of 42 U.S.C. § 1396a(a)(17), and is unique to the medically needy program. Neither AFDC nor SSI has any "methodology" for computing a spenddown of medical expenses. In both cash assistance programs, net income is measured against a set income standard with no adjustment for medical expenses;

medical expenses are not taken into account in any way. Therefore, Congress cannot possibly have meant that the spenddown calculation, the flexible taking into account of medical expenses against income, should be conducted by the "same methodology which would be employed under [AFDC or SSI]," since that methodology does not include any spenddown adjustment at all.

Moreover, Congress had something else very specifically in mind -- the rules for evaluating items of income -- when it enacted this language. The legislative history is clear that the phrase was inserted merely to correct a 1981 Health and Human Services ("HHS") regulatory amendment not involving the length of a budget period for spenddown purposes. See 46 Fed. Reg. 47980 (Sept. 30, 1981). That 1981 HHS amendment had

interpreted the Omnibus Budget Reconciliation Act of 1981, P.L. 97-35 ("OBRA") to give the states flexibility in measuring income; the "same methodology" requirement was intended to reinstate the use of particular cash assistance program methodologies in that area. See H.R. Rep. No. 97-757, Part I, 97th Cong., 2d Sess. 13 (1982). Congress expressly stated its intent to reinstate the prior regulatory scheme, and specifically endorsed other HHS regulations which had not been amended following OBRA, including the one which permits a six-month spenddown period. Id.; see Hogan v. Heckler, supra, 769 F.2d at 899-902; De-Jesus v. Perales, supra, 770 F.2d at 325-26. Moreover, this intent recently has been reaffirmed by Congress. See H.R. Rep. No. 98-861, 98th Cong., 2d Sess., 1366-67 (1984), reprinted in 1984

U.S. Code Cong. & Admin. News 697, 2054-55.[16/]

The court below appeared to recognize much of this when addressing the other issue before it on the appeal. Quoting the recent congressional statement that TEFRA "amended the Medicaid statute to clarify that Congress did not intend to change the policies governing the [. . .] eligibility of the medically needy from those in effect before OBRA," id., the court concluded: "Our examination of this

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16/ Concerns about the Secretary's implementation of the "same methodology" requirement in respects not here at issue, see id., led Congress in the Deficit Reduction Act of 1984, P.L. 98-369, § 2373(c), 98 Stat. 494, 1112, to impose a moratorium on the Secretary's imposition of sanctions, and to call for a report by the Secretary. No such report has yet been submitted. If there are any significant legislative developments affecting this case, we will of course advise the Court.

legislative history indicates that 42 U.S.C. § 1396a(a)(10)(C)(i)(III), requires a State to determine [Medicaid] eligibility in the same manner that was used prior to the recent series of amendments." A17-18.

This understanding, which is entirely correct, should lead inexorably to the conclusion that the continued use of a six-month spenddown was not interdicted by TEFRA. In Massachusetts, this practice has been in effect since 1969. See Mass. St. 1969, c. 800, § 1. The federal policy permitting it was adopted by the U.S. Department of Health, Education and Welfare in 1966 and incorporated in the first Medicaid regulations in 1969. That policy and practice have been consistently maintained, both prior to and following OBRA. It is inconceivable in light

of the legislative history that Congress intended to prohibit this widespread, longstanding and important practice by adopting a "technical correction from OBRA" while expressly endorsing the HHS authorizing regulation.17/

Yet the court below, when it turned to the spenddown issue, disregarded this clearly-applicable legislative history. The resulting erroneous construction of Title XIX, with its very significant practical consequences, should be reviewed and corrected by this Court.

17/ The respondents may suggest that the regulation become invalid instead because OBRA established monthly budgeting periods for the categorically needy. This argument is without merit for the reasons set forth in DeJesus, 770 F.2d at 323, n. 9 and in Hogan, 769 F.2d at 896 and n. 20.

III. THE DECISION BELOW IS IN CONFLICT WITH THE DECISIONS OF THIS COURT REGARDING THE ROLE OF THE SECRETARY IN INTERPRETING TITLE XIX.

The Commissioner emphasized below that the Secretary interprets Title XIX to permit spenddown periods of up to six months. "The Secretary's regulations plainly permit what [Massachusetts] has done." DeJesus v. Perales, supra, 770 F.2d at 322. Moreover, the Secretary's interpretation has been consistent and of long standing. Id., 770 F.2d at 322-23 and n. 8; Hogan v. Heckler, supra, 769 F.2d at 893, 896. Finally, as the court below noted, the Secretary had just forcefully reaffirmed this interpretation in Hogan v. Heckler. A23-24. But, while acknowledging the Commissioner's reliance on the Secretary's regulations, A23, the court failed to give them any considera-

tion, in much the same manner as it disregarded the legislative history and declined, on rehearing, to confront the reasoning of the First and Second Circuits. See A24-26.

In so doing, the court transgressed a long line of controlling decisions of this Court. Only last term this Court again affirmed that the Secretary's interpretation of Title XIX is entitled, at a minimum, to substantial deference. Connecticut Department of Income Maintenance v. Heckler, ___ U.S. ___, 105 S. Ct. 2210, 2214-15 (1985); Schweiker v. Hogan, 457 U.S. 569, 588 (1982). Moreover, when made pursuant to an explicit delegation of substantive authority, which the petitioner submits is present here, see p. 5, supra, the Secretary's interpretation is entitled to legislative

effect. Herweg v. Ray, 455 U.S. 265, 274-75 (1982); Schweiker v. Gray Panthers, 453 U.S. 34, 43-44 (1981). In ignoring the Secretary's interpretation, the decision below conflicts with each of these recent, governing decisions of this Court. See DeJesus v. Perales, supra, 770 F.2d at 327; Hogan v. Heckler, supra, 769 F.2d at 888, 892 and n. 12, 896-97, 902.

Moreover, this transgression was material to the result. Had the court given the Secretary's interpretation the deference required by the decisions of this Court, it perforce would have upheld the Secretary's regulations, and the six-month spenddown, in harmony with the legislative history and the decisions of the First and Second Circuits.

CONCLUSION

For the reasons set forth above, a writ of certiorari should issue to review the opinion and order of the Supreme Judicial Court for the Commonwealth of Massachusetts.

Respectfully submitted,

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APPENDIX

APPENDIX

COMMONWEALTH OF MASSACHUSETTS

SUPREME JUDICIAL COURT
FOR THE COMMONWEALTH

No. 3667

SANTOS RIVERA & others[1/] vs. COMMISSIONER OF PUBLIC WELFARE.

Hampden. January 9, 1985.
- June 12, 1985.

Present: Hennessey, C.J., Wilkins, Liacos, Nolan & O'Connor, JJ.

Administrative Law, Agency's interpretation of statute. Public Welfare, Medical assistance benefits. Medicaid.

CIVIL ACTION commenced in the Superior Court Department on May 20, 1983.

The case was heard by Raymond R. Cross, J.

The Supreme Judicial Court granted requests for direct appellate review.

H. Reed Witherby, Assistant Attorney General, for Commissioner of Public Welfare.

Steven A. Hitov for the plaintiff.

1/ Madeline McKenna and all others similarly situated. A Superior Court judge allowed McKenna's motion to intervene.

NOLAN, J. The Commissioner of Public Welfare appeals from a Superior Court judge's order allowing the plaintiffs' motion for summary judgment.[2/] The plaintiffs individually applied to the Department of Public Welfare (department) for medical assistance (MA) benefits. Each plaintiff worked full time but did not receive any medical benefits from her

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2/ The judge also granted the plaintiffs' motion for class certification, certifying two classes. The first class consists "of all Massachusetts residents who were at the time this action was filed or are currently medically needy, working applicants for or recipients of Medicaid and who were subjected to the defendant's practice of counting their gross income for Medicaid eligibility purposes. The second class [consists] of all those Massachusetts residents who were 'AFDC-related' medically needy applicants for or recipients of Medicaid currently or at the time this action was filed . . . are subjected to the defendant's six-month spend-down requirement in order to qualify or requalify for Medicaid benefits." The department does not contest the propriety of the class certification.

employer. In determining the plaintiffs' eligibility for MA benefits, the department considered the plaintiffs' gross income. The department did not disregard the taxes and social security payments withheld from the plaintiffs' income; rather it applied a flat $75 monthly income disregard. This method resulted in a determination that each plaintiff had income in excess of eligibility levels. The department multiplied each applicant's excess income by six to determine the amount each plaintiff must pay toward incurred medical expenses (spend down amount) before she could become eligible for MA benefits during the six-month budget period. In administrative proceedings, a department appeals referee upheld the department's methodology and determination of each plaintiff's eligibility.

The plaintiffs appealed to the Superior Court. On a motion for summary judgment, the judge ruled that the department had violated G.L. c. 118E, § 10 (5) (1984 ed.), by not deducting taxes and social security payments from an applicant's income when determining eligibility for MA benefits. The judge further ruled that the department's use of certain other eligibility procedures violated 42 U.S.C. § 1396a (a)(10)(C)(i)(III)(1982). Through these procedures, the department determined eligibility on a semiannual basis for applicants who, but for excess income and resources, would be eligible for Aid to Families with Dependent Children (AFDC).[3/] In contrast, the department determined eligibility on a

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3/ AFDC-related medically needy applicants.

monthly basis for applicants who received or were deemed to receive AFDC.[4/] We granted the parties' joint application for direct appellate review. For the reasons stated below, we conclude that the department did not violate G.L. c. 118E, § 10 (5), by the methodology used in determining income for eligibility purposes but that the department's use of a six-month budget period for spend down purposes is improper.

We recently examined the MA benefits program concerning the determination of eligibility based on resource limits. Haley v. Commissioner of Pub. Welfare, 394 Mass. 466 (1985). This program is a cooperative State and Federal effort to

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4/ AFDC-related categorically needy applicants.

pay for medical services provided to categorically and medically needy individuals.[5/] Categorically needy individuals are those who receive or are deemed to receive cash assistance benefits. G.L. c. 118E, § 1 (1984 ed.). See 42 C.F.R. § 435.1(e) (1984). Medically needy individuals would be eligible for cash assistance but for excess income and resources. See G.L. c. 118E, § 1. "Such individuals may have sufficient income and resources for their basic maintenance but not for medical care costs." Haley, supra at 467. A person is eligible for MA benefits if his income is above cash assistance income eligibility standards but at or below MA

5/ See Haley, supra at 467-468, 472, for a full discussion of the MA benefits program.

benefits eligibility standards. 106 Code Mass. Regs. § 506.400 (1983). A person with income above MA benefits eligibility standards also is eligible if his excess income can be reduced by application of a spend down. See 106 Code Mass. Regs. §§ 506.500-506.580 (1983). Excess income is that portion of the income which exceeds the eligibility limits. 106 Code Mass. Regs. § 506.520. In applying a spend down, the individual uses the excess income to pay incurred medical expenses. See 106 Code Mass. Regs. §§ 506.540, 506.570. Once the excess income is absorbed by incurred medical expenses, the applicant is eligible for payment of any other covered medical expenses incurred during the applicable budget period. See 106 Code Mass. Regs. § 506.570.

Neither party disputes the facts of this action. The sole issue in this case concerns the propriety of the department's method of computing income eligibility for MA applicants. We briefly describe that method.

The department initiates its eligibility determination with an examination of an applicant's gross income. See 106 Code Mass. Regs. §§ 505.200, 505.210 (1983). The department converts an applicant's income to monthly amounts. 106 Code Mass. Regs. § 505.320 (1983). In AFDC-related cases, the department deducts $75 from the gross monthly income. 106 Code Mass. Regs. § 506.120(A). After computation of income disregards, 106 Code Mass. Regs. §§ 506.120 and 506.130, the department compares the "Net MA Income" with the applicable MA income

standard. 106 Code Mass. Regs. § 506.400. An applicant with net income at or below the MA income standards is eligible for benefits.

"If Net MA Income is greater than the MA Income Standard, eligibility may be established on the basis of spend-down provisions." 106 Code Mass. Regs. § 506.400. In order to establish eligibility, an applicant must submit paid or unpaid medical bills which exceed his spend down liability. 106 Code Mass. Regs. § 506.540. The department uses a six-month spend down period. 106 Code Mass. Regs. § 506.510. The spend down liability is six times the excess monthly income, the amount of net MA income which exceeds eligibility standards. 106 Code Mass. Regs. § 506.520. Once the spend down liability is absorbed, an applicant

"is eligible for payment of all covered medical expenses incurred during that spend-down period, other than those submitted to meet the spend down liability." The applicant also must continue to meet all other eligibility requirements during the balance of the spend down period. 106 Code Mass. Regs. § 506.570.

1. Income disregards. This action presents an anomalous situation where an apparent incongruity exists in the statutes and regulations which control the income eligibility aspect of the MA benefits program. Title XIX, through a recent amendment, requires the State to use the "same methodology" to determine eligibility for MA benefits "which would be employed under the appropriate State plan [for cash assistance] to which such

group is most closely categorically related." 42 U.S.C. § 1396a(a)(10)(C)(i) (amended by Tax Equity and Fiscal Responsibility Act, Pub. L. 97-248, § 137[b][8], 96 Stat. 378) (TEFRA). The plaintiffs are categorically related to AFDC recipients. In determining AFDC income eligibility, the department applies a $75 income disregard for work expenses. See 42 U.S.C. § 602(a)(8)(A)(ii) (1982). This disregard is applied to gross income. See 45 C.F.R. § 233.20(a)(6)(iii) (1984). See also Heckler v. Turner, 105 S. Ct. 1138, 1153 (1985) (mandatory tax withholdings encompassed in the flat sum disregard and no additional disregard for withholdings allowed). The department applies this same methodology in determining MA eligibility for AFDC-related medically

needy applicants. 106 Code Mass. Regs. § 506.120. General Laws c. 118E, § 10 (5), however, states that "taxes, social security payments or, in the absence thereof, mandatory payments to a retirement system, union dues, and other reasonable and usual costs of earning wages as approved by the department; provided, however, that the latter shall be no greater than two dollars and fifty cents per week or eleven dollars per month" are exempt from income for MA purposes.

In adopting the program to provide medical assistance to medically needy individuals, the Legislature intended to maximize Federal financial participation. G.L. c. 118E, § 1. See ABCD, Inc. v. Commissioner of Pub. Welfare, 378 Mass. 327, 334-335 & n.13 (1979). To further

that goal, the Legislature adopted an MA benefits program designed "to comply with the Federal statutory and regulatory scheme." Haley v. Commissioner of Pub. Welfare, supra at 472. "Furthermore, St. 1969, c. 800, § 10, provides that the provisions of G.L. c. 118E are severable and that any provision 'in violation of any federal rule or regulation established by the [HHS] as a condition for receiving federal funds in connection with any program administered by said department . . . shall be null and void and such violation shall not affect or impair any of the remaining provisions.'" Id. at 472-473.

The department argues that determining MA income eligibility through the use of the additional disregards of G.L. c. 118E, § 10 (5), jeopardizes continued

Federal financial participation. The plaintiffs respond that Federal law only requires the State to determine eligibility for AFDC-related MA applicants no more restrictively than for AFDC recipients; the State may treat such applicants less restrictvely than AFDC recipients. The judge agreed with the plaintiffs that "nothing in [the Federal law] limits income deductions to the flat $75." The judge's conclusion was based on an erroneous belief that G.L. c. 118E (1984 ed.) enumerates the deductions from income under the AFDC plan. General Laws c. 118E pertains only to the MA benefits program. AFDC is controlled by G.L. c. 118 (1984 ed.) and applicable Federal law. See Civetti v. Commissioner of Pub. Welfare, 392 Mass. 474, 475-476 (1984); ABCD, Inc. v. Commissioner of Pub. Welfare, 378 Mass. 327, 331-333 (1979).

Basically, this dispute concerns the interpretation and effect of the "same methodology" language which appears in 42 U.S.C. § 1396a(a)(10)(C)(i)(III). This language was the result of several amendments by which Congress sought to clarify the MA eligibility requirements. Congress has experienced difficulty in conveying the purpose of the language changes to the United States Department of Health and Human Services (HHS). See H.R. Rep. No. 861, 98th Cong. 2d Sess., reprinted in 1984 U.S. Code Cong. & Ad. News 1445, 2055*/ (H.R. Rep. 861).

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*/ Petitioner's Note: The "opinion . . . delivered upon the rendering of the judgment . . . sought to be reviewed," Supreme Court Rule 21.1(k), referenced pages "751, 1361"; but the Official Reports of the Supreme Judicial Court subsequently corrected this reference as set forth in the text. See 395

(footnote continued)

As a result, Congress imposed a moratorium which required HHS to "not take any compliance, disallowance, penalty, or other regulatory action against a State during the moratorium period . . . by reason of such State's plan under Title XIX . . . being determined to be in violation of [42 U.S.C. § 1396a(a)(10)(C)(i)(III)]." Deficit Reduction Act of 1984, Pub. L. 98-369, Title III, § 2373(c), 98 Stat. 1112. Congress adopted the moratorium because HHS had "implemented [the same methodology] provision in an overly literal fashion, without taking into account the

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(footnote continued)

Mass. 189, 194 (Corrected Page). References infra to H.R. Rep. 861 at A16, A17 n.6 (twice), and A26 are set forth in the corrected version. The original references were 1361, 1360 and 1361, and 1361-1362, respectively.

intent of the TEFRA clarification." H.R. Rep. 861, at 2055. In its most recent statement concerning this language, Congress stated that TEFRA "amended the Medicaid statute to clarify that Congress did not intend to change the policies governing the eligibility of the medically needy from those in effect before OBRA [Omnibus Budget Reconciliation Act of 1981, Pub. L. 97-35]." Id.[6/]

6/ OBRA amended 42 U.S.C. § 1396, to give the States "certain flexibility in structuring their medically needy programs." H.R. Rep. 861, at 2054. Prior to this amendment, States could employ less restrictive income and resources eligibility standards or methodologies than those used in the similar cash assistance programs. Id. After OBRA, HHS issued regulations which allowed the "States to impose more restrictive standards and methodologies than under previous law." Id. at 2055. See Hogan v. Heckler, 597 F. Supp. 1106, 1110-1111 (D. Mass. 1984). In further amending 42 U.S.C. § 1396 by TEFRA, Congress at-

(footnote continued)

Our examination of this legislative history indicates that 42 U.S.C. § 1396a(a)(10)(C)(i)(III), requires a State to determine MA eligibility in the same manner that was used prior to the recent series of amendments. Presently, 42 C.F.R. § 435.831(a)(1) requires the department to "deduct amounts that would be deducted in determining eligibility under the State's AFDC plan" in determining income eligibility for AFDC-related MA applicants. To do otherwise could jeopardize Federal financial participa-

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(footnote continued)

tempted to "make[ ] clear that [HHS] had no authority to alter the rules that applied before September 30, 1981, with respect to medically needy income levels, medically needy resource standards, and the methodology for treating medically needy income and resources." Hogan v. Heckler, supra at 1111, quoting H.R. Rep. No. 97-757, Part I, 97th Cong. 2d Sess. 13 (1982).

tion.[7] See 42 C.F.R. § 435.1007 (1984). The same requirements existed prior to the amendments. Compare 42 C.F.R. § 435.831 (1978); 42 C.F.R. § 435.1007 (1978).[8] General Laws c. 118E, § 10 (5), as enacted, reflected the income disregards which were then applicable to AFDC recipients. See 42 U.S.C. § 602(a)(7)(1976); 45 C.F.R. §§ 233.20(a)(7)(i), 233.20(a)(11)(v)(a)

7/ We recognize that the moratorium prevents HHS from imposing any sanction on a State for not using MA eligibility standards which are more restrictive than the related cash assistance program. We find it unnecessary to examine the moratorium to determine to what extent the State may use a less restrictive standard.

8/ The department notes that 42 C.F.R. § 435.1007 refers to 42 C.F.R. § 436.831, and contends that this is a typographical error. We need not view this reference as error because 42 C.F.R. §§ 435.831 and 436.831 contain the same pertinent language.

(1978) (disregard for work related expenses). Cf. 45 C.F.R. §§ 233.20(a)(7)(i), 233.20(a)(11)(1984) (flat $75 disregard and no disregard for work related expenses). See also Heckler v. Turner, 105 S. Ct. 1138, 1142-1147 (1985). This indicates that the Legislature intended to provide the same treatment for medically needy MA applicants as was provided categorically related applicants.

In determining that the department improperly disregarded G.L. c. 118E, § 10 (5), the judge relied on a recent amendment to § 10. However, he did not consider the effect of St. 1969, c. 800, § 10. The judge determined that the Legislature's amendment to G.L. c. 118E, § 10, subsequent to OBRA which changed the AFDC income disregards, indicated a legislative choice "to go beyond the

income disregards of the federal law by specifying additional deductions under c. 118E." We disagree. Once Congress enacted the flat $75 income disregard for AFDC applicants, G.L. c. 118E, § 10 (5), was in conflict with 42 C.F.R. §§ 435.831 and 435.1007. Section 10 (5), therefore, became null and void. St. 1969, c. 800, § 10. As § 10 (5) was null and void at the time, the Legislature did not provide for additional disregards by reenacting § 10 (5) in its 1982 amendments.

Statute 1969, c. 800, § 10, clearly indicates that the Legislature intended G.L. c. 118E to comply with "any Federal rule or regulation established by [HHS] as a condition for receiving federal funds in connection with [the MA] program." We note that this case is distinct from Haley v. Commissioner of Pub.

Welfare, 394 Mass. 466 (1985). In Haley, we were faced with an interpretative opinion of an administrative body. Id. at 473. That interpretation was a clear departure from the agency's prior view and, therefore, not entitled to great deference. Id. at 474. In this action, there exists clear statutory language which is reflected in duly adopted regulations. See 42 U.S.C. § 1396a(a)(10)(C)(i); 42 C.F.R. § 435.831. As our previous discussion indicates, the regulations, even with the recent amendments, require the department to determine MA income eligibility in the same manner that the department uses to determine eligibility for the categorically related cash assistance program. We conclude, therefore, that pursuant to St. 1969, c. 800,

§ 10, G.L. c. 118E, § 10 (5), is null and void. The department's regulation properly applies the flat $75 disregard to income eligibility determinations for the categorically related group.

2. Six-month budget period. The department asserts that the judge erred in concluding that the six-month budget period for spend down purposes violated the "same methodology" language of 42 U.S.C. § 1396a(a)(10)(C)(i)(III). The department argues that the categorically related income eligibility determinations do not involve a spend down; therefore, there is no comparable methodology for the department to match in applying spend down provisions. The department further argues that Federal regulation explicitly allows a six-month budget period. The United States District Court for the

District of Massachusetts recently rejected similar arguments offered by HHS to support the application of the six-month spend down budget period to MA applicants categorically related to Supplemental Security Income (SSI) recipients. Hogan v. Heckler, 597 F. Supp. 1106, 1110-1113 (D. Mass. 1984).9/

In Hogan, the District Court recognized that "the length of the spenddown period is part of the methodology for evaluating income eligibility." Id. at 1110. We agree. There is no distinction between the spend down provisions as

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9/ On February 20, 1985, the Court of Appeals for the First Circuit granted an appeal of this case. We recognize that we do not have the benefit of that court's decision on this issue. We have determined, however, that our resolution of the instant dispute is necessary to prevent prejudicial delay to these parties.

applied to AFDC-related MA applicants and SSI-related MA applicants. See 42 C.F.R. § 435.831. The analysis in Hogan applies equally to this case. Although eligibility determinations for the categorically needy do not involve spend downs, such determinations do require the use of a budget period. See 42 U.S.C. § 1396a(a)(10)(A)(i); 42 C.F.R. §§ 435.110, 435.120; 42 U.S.C. § 1382(c)(1)(one-month budget period for SSI); 42 U.S.C. § 602; 45 C.F.R. § 233.31 (1984) (one-month budget period for AFDC). Calculating the spend down amount over a six-month prospective period results in the use of a six-month budget period for a portion of the income eligibility determinations for MA benefits. Furthermore, utilization of the six-month spend down period treats medically needy

applicants more restrictively than their categorically needy counterparts. The medically needy applicant must weigh six months of putative income against incoming medical bills where a categorically needy individual need only account for actual income. Congress clearly intended to prevent the States from pursuing such more restrictive treatment of the medically needy. H.R. Rep. 861, at 2055-2056. We conclude that the department must use a one-month budget period for spend down purposes.

For the reasons set forth above, we reverse that portion of the judgment which determined that the department violated G.L. c. 118E, § 10 (5), through the application of a flat $75 disregard in determining AFDC-related MA income eligibility, and we affirm that portion

of the judgment which determined that the department's use of a six-month budget period for spend down purposes violated 42 U.S.C. §1396a(a)(10)(C)(i)(III). We remand this matter to the Superior Court for further action consistent with this opinion.

So ordered.

COMMONWEALTH OF MASSACHUSETTS

Hampden, ss.

Superior Court
Civil Action
No. 83-684

SANTOS RIVERA, et al.

Plaintiffs

vs.

CHARLES M. ATKINS, Commissioner, Department of Public Welfare

Defendant

RULINGS ON (1) MOTIONS FOR (a) CLASS CERTIFICATION AND (b) SUMMARY JUDGMENT AND (2) ORDER FOR JUDGMENT

Plaintiffs seek class certification as a class of Medicaid recipients and applicants in Massachusetts.[1/] Plain-

1/ The plaintiffs seek certification for two separate classes. The first class pertains to the use of gross as opposed to net income for determining eligibility. The second class pertains to the six-month spend-down period used. For purposes of this discussion, the

(footnote continued)

tiffs challenge the Massachusetts Department of Public Welfare (Department) policy for determining Medicaid eligibility on two grounds: first, that the Department is using gross income rather than net income as the basis for determining eligibility, and second, that the spend-down is calculated on a six-month basis.[2/] Plaintiffs contend that the

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(footnote continued)

"plaintiffs" refers to both classes, without differentiation, except where the separate classes are specifically mentioned.

2/ Spend-down is the Department procedure whereby in calculating the amount of income available to an applicant for Medicaid, money which is utilized to meet medical expenses is not considered income. 42 U.S.C. §1396 (a)(17)(D). The monthly "spend-down" equals the amount by which a person's income exceeds the relevant monthly Medicaid limit. Before that person may be eligible for Medicaid, the applicant must incur medical expenses equal to the "excess." In Massachusetts, that excess is multiplied by six (the applicant must spend six times the spend-down before being eligible for Medicaid).

Department is in violation of both state and federal law.[3/] The Department contends that its eligibility calculations are based upon Department regulations which are not violations of federal and state law.[4/] In addition, the Department contends that the cost would be pro-

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3/ The state law in question is M.G.L.c. 118E, §10(5) which provides that taxes and social security payments are not to be considered income for purposes of Medicaid. The federal laws in question are 42 U.S.C. §1396 (a)(17), which requires that a state providing Medicaid determine eligibility comparably for all groups, and §1396a (a)(10)(c)(i) as amended by the Tax Equity and Fiscal Responsibility Act of 1982, which requires that a state medical assistance plan use a uniform method for determining eligibility for the medically needy and categorically needy.

4/ The Department cites 106 C.M.R. §§ 505.200 and 506.100-220 as the basis for determining deductions from income. The excess income is that which exceeds the Medicaid standard. 106 C.M.R. §506.520. A six-month calculation is used for spend-down. 106 C.M.R. §506.510.

hibitive if it were ordered to calculate eligibility in the manner asserted by the plaintiffs. Both parties have motions for summary judgment before the court. Because there are no material facts in dispute, this case is ripe for resolution as a summary judgment.

I. The Plaintiffs' Class Action Claims.

In order to proceed as a class action, the plaintiffs must establish that their proposed classes satisfy the numerosity, commonality, typicality and adequacy of representation requirements of Mass. R. Civ. P. 23.

All parties to this litigation have stipulated as to numerosity. (See Stipulation of Class Numerosity dated August 3, 1983.) The plaintiffs propose two classes. See fn. 1. The plaintiffs

in each purported class are challenging a Department regulation or policy. The same regulation or policy is challenged by every member of each of the classes. The first class (Class I) challenges the Department procedure for determining income level (gross rather than net). The challenge is to the Department's methodology as uniformly applied. There are no differing factual situations or variant claims by any class members. The exact same challenge to Department methodology is made by each and every class member. Therefore the prerequisites of commonality and typicality are satisfied. The same is true for the second purported class, which challenges the six-month spend-down requirement. Again, it is a uniformly applied Department policy, with no factual or legal variations between

plaintiffs. Therefore the commonality and typicality prerequisites for the second class are satisfied.

The plaintiffs in both classes are represented by attorneys well versed in welfare litigation. There is no question that they will litigate on behalf of all class members and in the best interest of all. The named plaintiffs, including the intervenors, are in the same situation factually and legally as are all members of each class respectively. There is nothing whatsoever to indicate that the plaintiffs would not adequately represent the class. Therefore the last prerequisite of the first part of Mass. R. Civ. P. 23 is satisfied.

Massachusetts requires that the class claims predominate over all other claims and that a class action be the best form

of action. Since the class claims here are the only claims, they clearly predominate. Because of the inefficiency of any other form of action, given the numbers, status and claims of the plaintiffs here, a class action is the best form of action.

Therefore this court grants the plaintiffs' motion for class certification for two classes. The first class is to consist of all Massachusetts residents who were at the time this action was filed or are currently medically needy, working applicants for or recipients of Medicaid and who were subjected to the defendant's practice of counting their gross income for Medicaid eligibility purposes. The second class is to consist of all those Massachusetts residents who were "AFDC-related" medically

needy applicants for or recipients of Medicaid currently or at the time this action was filed, and who, at the time this action was filed or currently, are subjected to the defendant's six-month spend-down requirement in order to qualify or requalify for Medicaid benefits.

II. The Claims Against Use of Gross Income Under M.G.L.c.118E, §10(5).

The plaintiffs in Class I challenge the Department procedure of using gross income for purposes of spend-down computation. The plaintiffs contend that M.G.L. c.118E, §10(5) mandates that the Department deduct taxes and social security, among other things, from the gross income of "AFDC-related" applicants for Medicaid for purposes of computa-

tion.[5] The Department contends that the AFDC state plan mirrors the federal requirements and disregards a flat $75 pursuant to the Omnibus Budget Reconciliation Act of 1981, P.L. 97-35, (OBRA). The Department contends that there is nothing in the AFDC scheme mandating a separate disregard of taxes and social security payments. The Department states

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5/ The state of Massachusetts has chosen to participate in the federal Medicaid program both as to the "categorically needy" and to the "medically needy" as defined in 42 U.S.C. §1396 d (a). M.G.L.c.118E, §1. The history of Medicaid and the requirements thereunder are well documented in numerous other cases. Schweiker v. Hogan, ___ U.S. ___, 102 S.Ct. 2597 (1982); Brogan v. Miller, 537 F.Supp. 139 (1982). That discussion will be omitted from this case because there is no contention as to the Medicaid program itself or its adoption by Massachusetts. Rather, the issues here relate to the Department's application of that program as it pertains to the "medically needy."

that specific disregards would violate 42 C.F.R. §435.831.[6/]

The Massachusetts law at issue here, M.G.L.c.118E, has been amended as recently as 1982. The 1982 amendment was subsequent to passage of OBRA. At the time the legislature passed c.118E, as amended, it was well aware of OBRA. There is nothing in OBRA which limits income deductions to the flat $75.[7/] Following c.118E would not violate OBRA.

6/ 42 C.F.R. §435.831(d) provides eligibility for "medically needy" persons if they incur medical bills equal to the amount of their income that exceeds the Medicaid level. This is the "spend-down" described in fn. 2. The plaintiffs here are only those termed "AFDC-related" as opposed to "SSI-related" applicants.

7/ The Department cites 42 U.S.C. §1396a (a)(10)(c)(III) for support of its flat $75 deduction. However, that law specifically says that the Department must deduct amounts deducted under the state's AFDC plan. M.G.L.c.118E is the state law enumerating deductions to be made.

The state of Massachusetts has chosen to go beyond the income disregards of the federal law by specifying additional deductions under c.118E. It is not within the powers of the Department to overturn or disregard duly enacted legislation. If the legislature decides that the Department should not deduct taxes and social security payments from an applicant's income, then the legislature can amend c.118E to reflect that decision, just as it has recently amended c.118E to require those deductions.

Therefore, the Department is in violation of state law by refusing to deduct taxes and social security payments from applicant's income for purposes of spend-down computation. The Department is hereby ordered to comply with c.118E, §10 (5) in its computations of income for Medicaid purposes.

III. The Claims Against the Department's Six-Month Spend-Down Policy.

The plaintiffs in Class II challenge the Department procedure of requiring a Medicaid applicant to incur six times his or her spend-down amount before providing Medicaid coverage. The Department relies on 106 C.M.R. §506.510 and M.G.L. c.118E, §10 for this procedure. The plaintiffs contend that this procedure conflicts with 42 U.S.C. §1396 (a)(10) which requires a state to use the same methodology in determining the income of AFDC-related medically needy families as it uses in determining AFDC eligibility.[8/] The Department responds that

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8/ 42 U.S.C. §1396a (a)(10)(c)(i)(III) provides that where a state chooses to

(footnote continued)

the six-month spend-down is not a "methodology" of calculating income. In addition, the Department contends that acceptance of the plaintiffs' argument would require a radical expansion of the Medicaid program.

The Department does not contest that financial eligibility for AFDC applicants is determined on a monthly basis. See 42 U.S.C. §602(a)(13). This methodology permits the Department to examine an applicant's income on a month-by-month basis to reflect more realistically the

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(footnote continued)

extend Medicaid to the medically needy, the plan must describe "... the single standard to be employed in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligibility, ...and which shall be the same methodology which would be employed under the appropriate state plan...to which such group is most closely categorically related."

income actually available to an applicant. That monthly determination comports with federal law. However, where an applicant is in what is termed the AFDC-related medically needy group, the applicant's income is evaluated semi-annually. 106 C.M.R. §506.520. Therefore, by budgeting AFDC-related categorically needy Medicaid applicants on a monthly basis and AFDC-related medically needy Medicaid applicants on a semi-annual basis, the Department is in fact operating two separate eligibility standards for two related groups. The Department's contention that the six-month spend-down is not a determination of income eligibility is totally without merit. Therefore, the Department procedure is in

violation of 42 U.S.C. §1396a (a)(10)(c)(i)(III).[9/]

The problem found here is that M.G.L. c.118E, §10, as amended, continues to expressly require a six-month spend-down. Unlike the portion of the statute discussed in Part II (c.118E, §10[5]), this portion of c.118E is in direct conflict with federal law. To the extent that M.G.L. c.118E, §10 conflicts with federal law (the six-month spend-down requirement), it must be voided pursuant to the Supremacy Clause of the United States Constitution.

9/ The history of 42 U.S.C. §1396a (a)(10), as cited by the Department, in fact supports this finding. Originally the statute said that eligibility standards should be "comparable." As amended by the Tax Equity and Fiscal Responsibility Act of 1982, the statute now says "single." P.L. 97-248, §137. This court notes that the strengthening of that language is a clear indication that Congress intended one method of eligibility computation.

To the extent that the Department relies on 42 C.F.R. §435.831, that argument must also fail. That regulation was promulgated prior to the enactment of OBRA and at the time did not conflict. Subsequent to the passage of 42 C.F.R. §435.831, federal law has been passed to require monthly eligibility determinations for AFDC applicants. Consequently, 42 C.F.R. §435.831 would not control. In addition, there is a saving provision within the regulation which requires that eligibility be based on countable income as determined under the applicable standard. 42 C.F.R. §435.831(b). The applicable standard in Massachusetts, as discussed above, is a monthly standard.

Finally, the Department contends that the large potential cost of using the

same standard for medically needy and categorically needy is sufficient justification to disregard the law. This court finds absolutely no support for a proposition that the law may be ignored because it might be costly to obey it.

Accordingly, this Court will grant plaintiffs' motion for class certification for the two classes described in Part I of this order. This Court grants the two plaintiff-classes' motion for summary judgment and orders that the Department of Public Welfare:

1) Apply M.G.L. c.118E, §10(5) in determining income for all AFDC-related Medicaid applicants or recipients;

2) Impose a spend-down requirement calculated on a one-month basis for all AFDC-related Medicaid applicants or recipients.

3) Pay reasonable attorney's fees and costs to the Plaintiffs pursuant to 42 U.S.C. §1983 and 42 U.S.C. § 188.

It is Ordered that an appropriate judgment enter herein.

s/s R.R. Cross
Justice of the Superior Court

Entered: March 26, 1984

MASSACHUSETTS DEPARTMENT OF
PUBLIC WELFARE
DIVISION OF HEARINGS
APPEAL DECISION

Appeal No. 98996
Denied

DECISION DATE: April 27, 1983

NAME: Santos Rivera

ADDRESS: 3421 Main Street, Springfield, MA 01107

DATES: 3/28/83 Filing 4/14/83 Hearing

JURISDICTION:

Notice dated 2/3/83 was sent to the appellant stating the Department had denied the appellant's application for Medicaid because: of excess income - "You can not meet surplus amount 106 CMR 506.400" (Exhibit A).

The appellant filed this appeal on 3/28/83, and, therefore, it is timely (106 CMR 343.140(B)).

The denial of an application is grounds for appeal (106 CMR 343.230(A)).

ACTION BY DEPARTMENT:

The Department has denied the appellant's application for Medicaid Assistance.

ISSUES:

Does the appellant have net income in excess of the eligibility standards? Did the Department correctly determine net countable income? Was the appellant's surplus income calculated correctly?

SUMMARY OF EVIDENCE:

Notice dated 2/3/83 was also sent informing the appellant of the amount of surplus income calculated by the Department. This notice explained the process by which eligibility could be established on the basis of that surplus. (Exhibit B).

The Department representative submitted into evidence the wage information (Exhibit C) and the worksheet evaluating the appellant's income (Exhibit D) and reviewed for the benefit of the Referee and the appellant the calculations set forth therein.

The appellant was represented by a staff attorney from Western Massachusetts Legal Services. The appellant's counsel argued:

(a) that the Department incorrectly determined available countable net income in violation of Massachusetts Law Chapt. 118E, Sec. 10(5) and Federal Law and regulation. Specifically, counsel contended that the Department incorrectly applied the Work-Related Expense deduction (WRE) to the appellant's gross monthly income amount rather than to the

net monthly income amount which is the amount after mandatory federal tax, FICA, and state tax deductions;

(b) that the Department incorrectly determined MA eligibility requirements in accordance with Spend-down requirements. The representative argued that Spend-down eligibility requirements for the "medically needed" was an incorrect application of relevant federal law and regulations. The advocate argued that eligibility for the "medically needed" should be the same as "categorical eligibility". The representative submitted into evidence MGL Chapter 118E, Sec. 10 (Exhibit F), federal regulation 42 USC Sec. 1396a(10) (C) (i) (Exhibit J), and Public Law - 97-248 (Sept. 3, 1982) Amending Sec. 1902 (a) (10) (C) (i) (Exhibit K).

FINDINGS OF FACT:

The record shows and I so find:

1) That the appellant filed an application for Medical Assistance on January 13, 1983. (See MA Application (Exhibit E));

2) That the appellant filed for herself and two (2) dependent children (Ibid);

3) That it was undisputed that the appellant is employed full-time and has earned income. (testimony and See Exhibits C, E, and G);

4) That the Department correctly allowed a $75.00 monthly deduction from gross wages (Work-Related Expense deduction. See 106 CMR 506.120(A)(1). The Department correctly applied the standard of need to the appellant's net MA

Income (amount after the allowable earned income deduction, ie., $75.00 WRE). The standard of need for a family of three (3) is $435.00 (106 CMR 506.410). The Department erred in calculating excess Net Monthly Income (excess net monthly income - standard of need). Excess Net Monthly Income is calculated as follows: $535.30 - $435.00 = $100.30 (The Department incorrectly calculated $90.30) (See 106 CMR 506.400).

The Referee finds the surplus for six (6) months is $601.80 ($100.30 x 6). See 106 CMR 506.500, 506.510, & 506.520.

CONCLUSIONS OF LAW:

The Department correctly determined that the appellant was entitled to a work-related expense deduction of $75.00 monthly from gross wages. 106 CMR 506.120(A).

The Department correctly calculated the appellant's net income and six month surplus in accordance with procedures set forth at 106 CMR 506.000, 506.620. The Department erred in the mathematical calculation of the excess net monthly income and 6 month surplus amount. Therefore, if the appellant incurs medical expenses in excess of the six month surplus, as determined by the Referee, and if the appellant meets all other conditions of eligibility at such time, Medicaid will be responsible for all approved medical expenses which are in excess of the surplus.

106 CMR 343.610 at (c) states the Referees shall not render decisions which require their determination of the legality of the Department regulation, and further, "if the legality of the Department regulation is at issue, the Referee

shall render a decision that (s)he can not rule on that issue and shall base his decision on the applicable regulation". Therefore, this Referee does not rule the legal issues raised by the appellant's representative.

This appeal is therefore denied.

ACTION FOR CSAO:

Send new notice to the appellant for the surplus for six months as found in "Findings."

s/s
Edward J. Collins
Welfare Appeals Referee.

Copy: Steven Hitov/WMLS
145 State St., Spfld., MA

MASSACHUSETTS DEPARTMENT OF
PUBLIC WELFARE
Division of Hearings
APPEAL DECISION

Appeal No: 101327
Denied

DECISION DATE: June 07 1983

NAME: Madeline McKenna

ADDRESS: 14 Palmer Road, Three Rivers, MA 01080

DATES: _____/_____
Filing Hearing

JURISDICTION:

Notices dated 4/5/83 and 5/19/83, as corrected, were sent to the appellant stating that the Department had denied the appellant's application for Medicaid because: your income exceeds Medical Assistance program limits. 106 CMR 506.400 (Exhibit A). The appellant filed this appeal on 5/18/83, and, therefore, it is timely (106 CMR 343.140(B)).

The denial of an application is grounds for appeal (106 CMR 343.230(A)).

ACTION BY DEPARTMENT:

The Department has denied the appellant's application for Medicaid Assistance.

ISSUES:

Does the appellant have net income in excess of the eligibility standards?

Was the appellant's surplus income calculated correctly?

Can the Department pay for prior authorized dental services?

SUMMARY OF EVIDENCE:

Notices dated 4/4/83 and 5/19/83, as corrected, were also sent informing the appellant of the amount of surplus income calculated by the Department. This notice explained the process by which

eligibility could be established on the basis of that surplus. (Exhibit B).

The Department representative submitted into evidence verifications of the appellant's income (Exhibit C) and reviewed for the benefit of the Referee and the appellant the calculations set forth therein.

The appellant stated that in December, 1982 a favorable appeal decision issued approving Orthodontic treatment. The appellant submitted into evidence - "Request for approval, MA-11" (Exhibit G).

The appellant also submitted into evidence an "Orthodontic Treatment Contract" (Exhibit F). The appellant requested the bill be applied to meet her surplus.

FINDINGS OF FACT:

The Department correctly calculated the appellant's monthly net income to be $531.66, which is $106.66 in excess of the eligibility standard of $425.00 (the exemption for a family of 2). The surplus for six months is $639.96.

On December 6, 1982 the Department approved Orthodontic services, service codes #060817, (1) unit and #060861, (12) units. (On or about December 6, 1982, the appellant received AFDC for herself and dependent child. Orthodontic services were approved for the dependent) See MA-11, Exhibit C.

Service code 060817 is intended to meet costs for Radiographs - Orthodontic X-ray. 106 CMR 420.422(F). 060817 is for initial fees (including diagnosis, models, photograph, and x-rays). 106

CMR 420.608. Service code 060861 concerns orthodontic treatment, active, first year, including a retainer. 106 CMR 420.428(a).

The appellant's AFDC assistance terminated on 12/9/82 because her earned income exceeded AFDC limits. The appellant continued to be eligible for MA until 3/30/83. The appellant applied for MA-AFDC on March 30, 1983.

106 CMR 420.428 provides that "both limited and full Orthodontic treatment are reimbursable only for recipients under the age of 21. However, regardless of the recipient's age, the Department will pay for the continuation of full Orthodontic treatment as long as the recipient remains eligible for Medical Assistance."

106 CMR 420 states that the Department will not pay for a prior-authorized

service when the recipient's Medical Assistance eligibility is terminated on or before the date of service.

Service codes 060817 and 060861 require prior authorization (106 CMR 420.409(C).

I have found that the appellant's MA eligibility terminated on March 30, 1983. I conclude therefore, that the Department cannot pay for the continuation of Orthodontic treatment as of the date of MA ineligibility.

I conclude therefore, that the appellant's MA eligibility is subject to 106 CMR 506.000 - 506.620 spend-down eligibility.

The Department correctly calculated the appellant's net income and six month surplus in accordance with the procedures set forth at 106 CMR 506.000 - 506.620. Therefore, if the appellant incurs medi-

cal expenses in excess of the six month surplus, and if the appellant meets all other conditions of eligibility at such time, Medicaid will be responsible for all approved medical expenses which are in excess of the surplus.

ACTION FOR WSO:

None.

s/s
Edward J. Collins
Welfare Appeals Referee

COMMONWEALTH OF MASSACHUSETTS

SUPREME JUDICIAL COURT
FOR THE COMMONWEALTH,

AT BOSTON, June 12, 1985.

IN THE CASE NO. SJC-3667

SANTOS RIVERA & others
v.
COMMISSIONER OF PUBLIC WELFARE

pending in the Superior Court Department of the Trial Court for the County of Hampden No. 83-684

ORDERED, that the following entry be made in the docket; viz., --

We reverse that portion of the judgment which determined that the department violated G.L. c. 118E, § 10 (5), through the application of a flat $75 disregard in determining AFDC-related MA income elibility, and we affirm that portion of the judgment which determined that the

department's use of a six-month budget period for spend down purposes violated 42 U.S.C. § 1396a(a)(10)(C)(i)(III). We remand the matter to the Superior Court for further action consistent with the opinion.

BY THE COURT,

s/s Frederick J. Quinlan
Assistant Clerk

June 12, 1985

See opinion on file.

SUPREME JUDICIAL COURT
FOR THE COMMONWEALTH
ROOM 1412 COURT HOUSE
BOSTON, MASSACHUSETTS 02108

JEAN M. KENNETT (617) 725-8055
Clerk
FREDERICK J. QUINLAN
Assistant Clerk

September 26, 1985

H. Reed Witherby, A.A.G.
1 Ashburton Place
Boston, MA 02108

Dear Attorney Witherby:

RE: SJC-3667
SANTOS RIVERA & others
vs.
COMMISSIONER OF PUBLIC
WELFARE

Your Petition for Rehearing has been considered by the Court and is denied.

Very truly yours,

L. Holliey White
Assistant Clerk, pro tem

cc: Steven A. Hitov, Esquire
Western Mass. Legal Services
145 State Street
Springfield, MA 01103

Rene Reixach, Esquire
Greater Upstate Law Project
101 Powers Building
Rochester, NY 14614

COMMONWEALTH OF MASSACHUSETTS

HAMPDEN, SS. SUPERIOR COURT
C.A. No. 83-684

SANTOS RIVERA, et al.,
Plaintiffs

v.

CHARLES ATKINS,
Defendant

AMENDED JUDGMENT

This case having been commenced by a complaint filed on May 20, 1983, and the defendant having answered on June 27, 1983, and upon plaintiffs' motions for class certification and summary judgment and the memoranda, stipulation and oral argument of both parties in regard thereto, it is hereby

ORDERED, that:

1. A class be certified in this action consisting of all those AFDC-related medically needy applicants for or recipients of Medicaid who have been, are being or will be subjected to the defendant's six-month spend-down requirements in order to qualify or requalify for Medicaid benefits;

2. A subclass be certified in this action consisting of all those AFDC-related medically needy working applicants for or recipients of Medicaid who have been, are being, or will be subjected to the defendant's practice of counting for Medicaid eligibility purposes their gross income without disregarding at least the amount withheld from their checks for taxes and social security payments;

3. A declaration issue pursuant to M.G.L. ch. 231A stating that the defen-

dant's practice of imposing a six-month spend-down requirement on AFDC-related medically needy applicants for or recipients of Medicaid when such a requirement is not imposed on AFDC-related categorically eligible applicants for or recipients of Medicaid violates 42 U.S.C. § 1396a(a)(10)(C)(i)(III);

4. A declaration issue pursuant to M.G.L. ch. 231A stating that, to the extent that M.G.L. ch. 118E, § 10 and 106 C.M.R. §§ 506.510 and .520 and other Department of Public Welfare regulations mandate or authorize the imposition of a six-month spend-down on AFDC-related medically needy applicants for or recipients of Medicaid, those provisions are void pursuant to the Supremacy Clause of the United States Constitution;

5. A declaration issue pursuant to M.G.L. ch. 231A stating that the defendant's practice of computing the spend-down of a working AFDC-related medically needy applicant for or recipient of Medicaid without deducting from that person's income at least the amount withheld from his or her check for taxes and social security payments violates M.G.L. ch. 118E, § 10(5);

6. The defendant and the Department of Public Welfare are permanently enjoined from imposing upon AFDC-related medically needy applicants for or recipients of Medicaid more than a one-month spend-down requirement;

7. The defendant and the Department of Public Welfare are permanently enjoined from refusing to disregard the amounts withheld for taxes and social security payments from the paychecks of

working AFDC-related medically needy applicants for or recipients of Medicaid when computing the monthly spend-downs of such applicants or recipients, in accordance with M.G.L. ch. 118E, § 10;

8. The defendant, through the Department of Public Welfare, within 45 days of the date of this order, or within such longer period as the Court may allow upon Motion, redetermine the eligibility for Medicaid of each class member herein in compliance with ¶¶ 6 and 7, supra, and inform each class member of the amount of his or her monthly spend-down which must be met in order for him or her to be eligible for Medicaid;

9. The defendant, through the Department of Welfare, within 45 days of the date of this order, recompute the eligibility of the named plaintiffs pur-

suant to ¶¶ 6 and 7, supra, from the dates of their applications for Medicaid and pay them, for any month(s), any amounts incurred by them for medical expenses which exceeded the amount of their monthly spend-downs; and

10. The plaintiffs are the prevailing party in this action and are entitled to an award of an attorney's fee pursuant to 42 U.S.C. § 1988, the amount of said fee to be determined by the parties or upon motion to this Court, or both.

DATED: May 24, 1984

s/s R. R. Cross
Justice of the Superior Court

EDITOR'S NOTE

THE FOLLOWING PAGES WERE POOR HARD COPY AT THE TIME OF FILMING. IF AND WHEN A BETTER COPY CAN BE OBTAINED, A NEW FICHE WILL BE ISSUED.

NO. 85-632

IN THE
SUPREME COURT OF THE UNITED STATES

October Term, 1985

ORIGINAL

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OFFICE OF THE CLERK
SUPREME COURT, U.S.

CHARLES ATKINS, Commissioner of the
Massachusetts Department of Public Welfare,

Petitioner,

-vs-

SANTOS RIVERA, MADELINE McKENNA,
and all others similarly situated,

Respondents.

MOTION FOR LEAVE TO
PROCEED IN FORMA PAUPERIS

Respondent Madeline McKenna asks leave to file the attached Brief in Opposition to Petition for a Writ of Certiorari to the Supreme Judicial Court for the Commonwealth of Massachusetts and to proceed in forma pauperis pursuant to Rule 46. Upon respondent's affidavit of indigency the filing fee was waived by the Massachusetts Superior Court.

The affidavit of respondent Madeline McKenna in support of this motion is annexed hereto.

RENE H. REIXACH, JR., ESQ.
Counsel of Record for
Respondent Madeline McKenna
Greater Upstate Law Project
101 Powers Building
Rochester, New York 14614
Telephone: 716-454-6500

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1985

NO. 85-632

CHARLES ATKINS, Commissioner of the Massachusetts Department of Public Welfare,

Petitioner

vs.

SANTOS RIVERA, MADELINE McKENNA, and all others similarly situated,

Respondents

AFFIDAVIT IN SUPPORT OF MOTION FOR LEAVE TO PROCEED IN FORMA PAUPERIS

I, Madeline McKenna, being first duly sworn, depose and say that I am a respondent in the above-entitled case; that in support of my motion to proceed without being required to prepay fees, costs or give security therefor, I state that because of my poverty I am unable to pay the costs of said proceeding or to give security therefor.

I further swear that the responses which I have made to the questions and instructions below relating to my ability to pay the cost of opposing the appeal are true.

1. Are you presently employed? No.

   a. If the answer is yes, state the amount of your salary or wages per month and give the name and address of your employer.

   b. If the answer is no, state the date of your last employment and the amount of the salary and wages per month which you received.

   July 26, 1985 - $1169.86/month

2. Have you received within the past twelve months any income from a business, profession or other form of self-employment, or in the form of rent payments, interest, dividends, or other source? Yes.

   a. If the answer is yes, describe each source of income, and state the amount received from each during the past twelve months.

   Unemployment Compensation: $336/mo. since 8/8/85

3. Do you own any cash or checking or savings account?

   No.

4. Do you own any real estate, stocks, bonds, notes, automobiles, or other valuable property (excluding ordinary household furnishings and clothing)?

   Yes.

a. If the answer is yes, describe the property and state its approximate value.

One automobile valued at $400.00.

5. List the persons who are dependent upon you for support and state your relationship to those persons.

Chris McKenna - son.

I understand that a false statement or answer to any question in this affidavit will subject me to penalties for perjury.

Madeline McKenna
MADELINE MCKENNA

Subscribed and sworn to before me this 8th day of October, 1985.

Steven A. Hitov
STEVEN A. HITOV

My Commission Expires: 5/6/88

Let the applicant proceed without prepayment of costs or fees or the necessity of giving security therefor.

Justice of the Supreme Court

NO. 85-632

IN THE
SUPREME COURT OF THE UNITED STATES

October Term, 1985

CHARLES ATKINS, Commissioner of the
Massachusetts Department of Public Welfare,

Petitioner,

-vs-

SANTOS RIVERA, MADELINE McKENNA,
and all others similarly situated,

Respondents.

BRIEF FOR RESPONDENT MADELINE McKENNA IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME JUDICIAL COURT FOR THE COMMONWEALTH OF MASSACHUSETTS

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STATEMENT OF THE CASE

This case concerns whether 42 USC §1396a(a)(10)(C)(i)-(III), which requires a State Medicaid plan to use "the same methodology" in determining Medicaid eligibility as would be used in determining eligibility for the equivalent cash public assistance program (here Aid to Families with Dependent Children [AFDC]), allows Massachusetts to count six months' income in determining Medicaid eligibility while it counts only one month's income in computing AFDC eligibility* and also counts only one month's income for other Medicaid applicants. The court below held it did not. Petition, A25-26.

Respondent McKenna, a working mother earning only $3.50/hr., sought Medicaid coverage in order to continue orthodontic treatments for her minor son. Record Appendix below, p. 94; Petition, A57-59. Her son's teeth had been pulled and top braces installed under Medicaid while she was receiving AFDC. Record Appendix below, p. 97. Faced with a bill of $1,540 for bottom braces and adjustments to complete the prescribed care for her son, Id., she lost her full Medicaid coverage because she lost AFDC eligibility. By virtue of the six-month budgeting rule Medicaid coverage ceased to be available for her and her son.

The other respondent, Ms. Rivera,** also a working mother, incurred $414.00 of medical bills for herself and one of her minor children over a three-month period, including $314.00 in a single month. Record Appendix below, pp. 73-75. Although her liability for medical bills was computed under Medicaid as only $100.30/month, none of the bills was covered even in part by Medicaid because Massachusetts used a six-month budget period and required her to incur $601.80 of bills before Medicaid coverage would be available. Petition, A51.

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* The use of a one-month eligibility computation for AFDC is required by 42 USC §602(a)(13), as amended by P.L. 97-35, §2315(a). By §2171(a)(3) of that same act Congress enacted the "same methodology" language at issue herein.

** Respondent Rivera is not participating in this Court.

SUMMARY OF ARGUMENT

The decision below concerns the construction of a statute which Congress is currently re-examining and as to which further amendment is likely by early 1987, before a decision is likely to be reached on the merits if the petition were to be granted. Massachusetts, like other states, is otherwise obliged to operate its Medicaid program for families and children [the "AFDC-related" class here] differently than it does for other Medicaid recipients [the "SSI-related" class of aged, blind and disabled persons involved in Hogan v. Heckler, 769 F.2d 886 (1st Cir. 1985)]. Thus compliance with the judgment herein will not unduly burden Massachusetts, just as the use of one month Medicaid budgeting alone or dual one- and six-month systems has not burdened other large urban states. Moreover, the decision below is correct both for the reasons set forth below and for reasons unique to Massachusetts, and it should not be disturbed.

REASONS FOR DENYING THE WRIT

I

BEFORE THIS CASE IS LIKELY TO BE DECIDED ON THE MERITS CONGRESS SHOULD BE RE-EXAMINING THE STATUTE IN QUESTION

Given the current calendar of cases awaiting argument and the time required for consideration of the petition herein, it is likely that this case would not be argued on the merits until the fall of 1986.* By that time Congress is likely to be re-examining the scope of the "same methodology" provision of 42 USC §1396a(a)(10)(C)(i)(III) pursuant to §2373(c) of the Deficit Reduction Act of 1984, P.L. 98-369.

That statute enacted a moratorium on federal sanctions against States for alleged noncompliance with the "same methodology" requirement. It required the Secretary of the Department of Health and Human Services ("HHS") to report to Congress concerning the appropriateness and impact on both states and Medicaid recipients of the "same methodology" provision and to provide recommendations for changes in that requirement. P.L. 98-369, §2373(c)(3). That report was to have been filed within 12 months after the July, 1984 enactment of the statute, Id.; it is currently overdue and will presumably be filed shortly. Thereafter the moratorium will continue for another 18 months, P.L. 98-369, §2373(c)(2), until the spring of 1987 (assuming prompt filing of the HHS report).

There is every reason to believe that Congress will be closely examining the scope and meaning of the "same methodology" statute so as to resolve any uncertainties and to clearly establish federal policy in this area prior to the expiration of the moratorium. Already Congress has before it legislation

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* According to the count in U.S. Law Week, in addition to the 87 cases carried over there were 55 cases granted review this Term through November 4, 1985. Last Term petitions on which action was taken after January were carried over the Term. In a case like this, where the Department of Health and Human Services is not a party, the Court frequently requests that the United States file a brief before considering the petition, e.g. Blum v. Toomey, 435 U.S. 949 (1978). If such were done here the petition would likely not be ruled upon until February, 1986.

to clarify the scope of the moratorium, H.R. 1868, §9 (99th Cong., 1st Sess.) and the "same methodology" language has been the subject of extensive prior legislative consideration. P.L. 97-35, §2171(a)(3) revised the longstanding language of the statute, and after Congressional displeasure with HHS regulations interpreting it, e.g. 127 Cong.Rec. H7052 (Oct. 6, 1981; remarks of Rep. Waxman), the current language was enacted. See H.R.Rep. No. 757, Part 1, 97th Cong., 2d Sess. 13 (1982).

Consideration of the merits of this case is thus likely to proceed simultaneously with Congressional consideration of revisions to the statute. Not only should the establishment of national policy in this complex area be left to the Congress as a matter of principal and of judicial restraint, but also it will avoid the expenditure of the scarce resources of this Court on a matter of statutory construction that may be moot before it is decided. That is precisely what has happened before where a Medicaid policy was reviewed by this Court but the concerns of the States led to a Congressional resolution of the issue before the merits could be reached. Beltran v. Myers, 451 U.S. 625 (1981).

It is unlikely that any conflicting lower court opinions on this question will affect other States.* As a very practical matter the issue herein is of interest solely to Massachusetts, and as such should not be resolved by this Court.

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* Of the cases on the issue referred to in fn. 11 on p. 20 of the petition, the two from Illinois are long concluded [Srogan v. Miller, 537 F.Supp. 139 (N.D.Ill. 1982) and Coleman v. Miller, No. 82-C-6259 (N.D.Ill. 1984)], and the appeal in Cashman v. Perales, Civ. 85-0639-T (W.D.N.Y. Aug. 29, 1985), has been withdrawn by stipulation subject to reinstatement after disposition of this case by this Court (2d Cir. No. 85-7763 Nov. 1, 1985). Plaintiffs in the First and Second Circuit cases, Hogan v. Heckler, 769 F.2d 886 (1st Cir. 1985), and DeJesus v. Perales, 770 F.2d 316 (2d Cir. 1985), represented as well by the undersigned counsel herein, will not petition for certiorari if certiorari has been denied herein prior to the expiration (after possible extensions) of their time to petition for certiorari. Likewise in Cashman, where plaintiffs-appellants are represented by the undersigned counsel of record herein, the appeal will not be reinstated if the petition is denied herein.

II

THE USE OF A ONE-MONTH BUDGET PERIOD FOR THE AFDC-RELATED CLASS WILL NOT UNDULY BURDEN MASSACHUSETTS

The petition is predicated, in large part, on the different results reached by the court below and the court of appeals in Hogan v. Heckler, 769 F.2d 886 (1st Cir. 1985). What petitioner ignores is that the two cases apply to two different groups of Medicaid recipients, as to whom Massachusetts must already apply many different rules and procedures.

This case concerns the AFDC-related (families and children); Hogan concerns the SSI-related (the aged, blind and disabled). The budgeting procedures for determining eligibility for Medicaid for these two groups are, by virtue of the "same methodology" requirement, already vastly different for the two groups. Thus, for example, while a state must use at least the AFDC standard work expense disregard of $75.00 per month* in computing net earned income for the AFDC-related class, it must use the entirely different SSI disregards of $65/month plus half the remainder in computing net earned income for the SSI-related class in Hogan. See Calkins v. Blum, 511 F.Supp. 1073, 1092-1093 (N.D.N.Y. 1981), aff'd 675 F.2d 44 (2d Cir. 1982). That Massachusetts will, under the judgment below, have to further budget the class herein differently from other Medicaid applicants is hardly unique.

Massachusetts currently uses a one-month budget period for many nursing home patients, 106 C.M.R. §506.620(A), so the use of dual eligibility periods is nothing new to it. Other large urban States have been and are, by virtue of choice or litigation, in the same position of using dual eligibility periods. New York has always used a one-month budget period for almost all services other than inpatient hospital care, for

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* See Heckler v. Turner, ___ U.S. ___, 105 S.Ct. 1138, 84 L.Ed. 2d 138 (1985).

which it uses a six-month budget period. 18 NYCRR §360.5(d)-(1).* In Illinois, the State was required to use one-month budgeting for the SSI-related in 1982, Brogan v. Miller, 537 F.Supp. 139 (N.D.Ill. 1982), but it continued to use six-month budgeting for the AFDC-related until enjoined as to them two years later. Coleman v. Miller, No. 82-C-6259 (N.D.Ill. 1984).

Moreover, the alleged fiscal impact on Massachusetts (Petition, pp. 22-23) is a speculation of dubious validity that is not borne out by the experience of other States.** The $19.6 million estimated cost of implementation of the judgment below in its first year represents less than 2% of the 1985 Massachusetts Medicaid budget of $1,117,920,000 [from Joint Appendix in Hogan v. Heckler, supra, p. 122]. The reference at p. 23 of the Petition to a $208 million estimated cost increase for the SSI-related in Hogan is both irrelevent and misleading. Whatever implementation of one-month budgeting might cost for the SSI-related class in Hogan, the fact is that Massachusetts prevailed in that action. Additionally, that estimate is based upon figures contradicted by other data that Massachusetts itself submitted in the same case: The $208 million estimate was computed using an average Medicaid cost estimate of $6,000 per year per recipient [Joint Appendix in Hogan, p. 108], while a subsequent affidavit showed average costs of $3,528 for the disabled [Hogan Joint Appendix, pp. 118 and 121]. With data like that the cost estimates of petitioner, even in this case, are simply worthless.

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* Currently, and since early 1985, only inpatient hospital care has been subject to a six-month budget period; previously a six-month period was also used in New York for prosthetic devices including dentures.

** In Illinois, after the Coleman case, supra, the State's Medicaid budget for the affected group did not significantly increase after the changes from six-month to one-month budgeting required therein. For the AFDC-related class the pre-Coleman Fiscal Year 1983 expenditures were $35,610,000. In Fiscal Year 1985, the first full post-Coleman year, they were only $36,501,000. Illinois Department of Public Aid Bureau of Management and Budget, "Medical Assistance Expenditures by Recipient Category FY83-FY85." Indeed, the State of Illinois did not appeal in either case. California, another large urban state with an extensive Medicaid program, uses a one-month Medicaid budget period without apparent fiscal distress.

III

THE JUDGMENT BELOW IS CORRECT

The decision below, both as a matter of plain English and legislative history, is clearly correct. As the Supreme Judicial Court recognized, Petition A25-26, the choice of a budget period is inherently part of the "methodology" for determining income eligibility. Because the cash AFDC program uses a one-month budget period and thus counts only one month's income in determining eligibility, an AFDC applicant can go on AFDC for a month, obtain all needed medical care under Medicaid in that month, and cease participating in the program the next month. A subsequent new job, increased earnings or other increased income, will not deprive that AFDC recipient of that one month's Medicaid coverage by virtue of counting her income for the next five months. For respondents and the class, however, because six months' income is counted instead of one, they cannot utilize Medicaid at all without being reduced to the Medicaid level for six months.

Not only does this result fly in the face of the plain language of the statutory requirement for use of the "same methodology," but it ignores the fact that the "same methodology" language was part of the same act that mandated use of one-month AFDC budgeting. See p. 1 *, supra. By its very nature "income," the measure used to determine eligibility for both AFDC and Medicaid, is time related. Saying that respondent McKenna has $140 of income is to say nothing of use. If that were her hourly income she would be a large firm lawyer. If that were her daily income she would be "middle class." Since it was in fact her gross weekly wage, she is poor and must struggle just to meet the essential needs of her child and herself.

The petition also ignores the requirement of 42 CFR §435.401(c) prohibiting states from using "requirements for determining eligibility for [e.g. the medically needy class here] that are - (1) For families and children, more restrictive

than those used under the state's AFDC plan; ..." If the one-month period for counting income under AFDC is not part of the "methodology" as petitioner contends, and if it is not a "requirement" under this regulation, it is hard to imagine what it is. Plainly it is both.

The judgment below was also correct for a reason apparently unique to Massachusetts. Because the Massachusetts Medicaid income levels are slightly above those for AFDC, while people whose income fits in that gap are over income for AFDC, they receive Medicaid as AFDC-related medically needy with no spend-down. Despite its use of a six-month budget period for the AFDC-related with spend-downs, for those with no spend-down Massachusetts uses a one-month budget period. 106 C.M.R. §§506.400, 506.410, 506.500. This violates the requirement of 42 USC §1396a(a)(17) that Medicaid eligibility standards be "comparable for all groups"* and provisions of 42 CFR §435.831 implementing that statute. Neither permits the use of a dual standard based solely on how much income the medically needy applicant has.

The judgment below is correct and should not be reviewed.

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* While the courts below did not address the claims under 42 USC §1396a(a)(17), Petition, p. 11 n. 6, this one aspect of those claims can support the judgment below since it is based purely on a question of law requiring no further factual development. Schweiker v. Hogan, 457 U.S. 569, 585 n. 24 (1982). Further evidence would be required as to the claims that the Massachusetts six-month spend-down is unreasonable and inconsistent with the objectives of the Social Security Act, 42 USC §§1396a(a)(17)(A) and (C). Those arguments were neither made nor addressed in DeJesus v. Perales, 770 F.2d 316, 323 (2d Cir. 1985), so that decision would not necessarily conflict with relief under §1396a(a)(17) here. The analysis in DeJesus based on the "comparable standards" language of §1396a(a)(17) was limited to a comparison of the eligibility standards for the AFDC-related medically needy and the AFDC categorically needy, not a comparison of standards for two groups within the AFDC-related class here.

CONCLUSION

For the reasons stated the petition for a writ of certiorari should be denied.

Dated: November 8, 1985

Respectfully submitted,

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Supreme Court, U.S.
FILED
NOV 19 1985
JOSEPH F. SPANIOL, JR.
CLERK

No. 85-632

IN THE
SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1985

CHARLES ATKINS, Commissioner
of the Massachusetts
Department of Public Welfare,

Petitioner,

v.

SANTOS RIVERA, Madeline McKenna,
and all others similarly situated,

Respondents.

PETITIONER'S REPLY BRIEF IN SUPPORT OF CERTIORARI

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TABLE OF AUTHORITIES

Cases

DeJesus v. Perales, 770 F.2d 316 (2d Cir. 1985) 3, 4, 5, 6

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No. 85-632

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PETITIONER'S REPLY BRIEF IN SUPPORT OF CERTIORARI

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1. The respondents concede that there is a conflict on an important federal question. They seek to avoid review through the diversionary, and misleading, tactic of asserting likely congressional resolution.

There is no legislation pending in Congress which would amend 42 U.S.C.

§ 1396a(a)(10)(C)(i)(III) or otherwise affect this case.

Moreover, the moratorium[1/] relied upon by the Brief in Opposition at 3 has nothing to do with the issue presented here. It is a moratorium upon the imposition of "quality control" sanctions by the Secretary of Health and Human Services pursuant to what Congress thinks may be an overly strict application by HHS of the "same methodology" language. By regulation since the inception of Medicaid, the Secretary has always permitted flexibility to the States regarding the length of a spenddown period, and she did not change this position after the "same methodology" language was enacted. She argued, successfully,

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1/ P.L. 98-369, § 2373(c), 98 Stat. 494, 1112; see Pet. 30, n. 16.

in Hogan v. Heckler, 769 F.2d 886 (1st Cir. 1985) and in DeJesus v. Perales, 770 F.2d 316 (2d Cir. 1985), that "same methodology" has nothing to do with the length of the spenddown period.

Congress agrees with the Secretary (and the federal courts of appeals) that the length of the spenddown is not encompassed by the "same methodology" provision. See Pet. 28-30. Therefore, so far as Congress is concerned there is little reason to "reexamine" this issue.[2/] It is unlikely that the Secretary's report to Congress[3/] will even address this matter, which is com-

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2/ H.R. 1868, § 9 (99th Cong., 1st Sess.), relied upon by the Opposition at 4, would merely clarify the scope of the moratorium. The respondents' other legislative references, id., simply document the enactment of the "same methodology" provision.

3/ Called for by P.L. 98-369, § 2373(c).

completely separate from the concerns Congress expressed in seeking the report.[4/] It would be entirely fortuitous if any legislation enacted at the end of the moratorium period affected the question presented here.[5/]

4/ Id.; see H.R. Rep. No. 98-861, 98th Cong., 2d Sess., 1366-67, reprinted in 1984 U.S. Code Cong. & Admin. News 697, 2054-55.

5/ Moreover, there is no indication that HHS will submit a report in the near future; and since Congress by the moratorium has given itself 18 months after receipt of the report to react, it is unlikely that any congressional attention even to the questions addressed therein would occur before mid-1987.

In contrast, this case will certainly be heard this term if certiorari is granted without asking for the views of the United States. There appears to be little reason to ask for those views, since the Secretary's wholehearted support of the petitioner's position is already plainly attested to by her arguments in Hogan and DeJesus that a six-month spenddown always has been, and remains, legal and, indeed, expressly authorized by her regulation.

2. While paying lip service to the assertion that the decision below was correct, the respondents assiduously avoid any mention of the Secretary's governing regulation,[6/] and utterly fail to discuss the legislative history which makes clear that the congressional intent was not to invalidate, but to reaffirm that regulation. See Pet. 28-31.[7/]

6/ The reference to the Secretary's substantive -- not financial -- eligibility regulation, 42 C.F.R. § 435.401, which clearly does not apply, is another red herring. See Hogan, supra, 769 F.2d at 894, n. 15.

7/ In yet another diversionary move, the Brief in Opposition at 9 raises a new wrinkle on an issue which was not reached below (42 U.S.C. § 1396a(a)(17)) but was rejected in DeJesus and in Hogan. The wrinkle was not even raised below; it was specifically rejected, however, in Hogan, 769 F.2d at 888 n. 2 and 896.

Actions speak louder: the plaintiff classes in Hogan and DeJesus, represented by the same counsel as respondents here, have decided not to seek review in this Court despite the serious adverse impact of those decisions on them. Brief in Opposition at 4, n.*. Since those cases, as this one, are part of a serious and direct conflict on an important federal question, it seems quite clear that this decision follows from a judgment that this Court, upon such review, would determine that they were correctly decided, in contrast to the decision below.

The petitioner respectfully suggests that this Court might appropriately consider summary reversal.

Respectfully submitted,

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Date: November 15, 1985

Supreme Court, U.S.
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JOSEPH F. SPANIOL, JR.
CLERK

No. 85-632

IN THE
SUPREME COURT OF THE UNITED STATES
October Term, 1985

CHARLES ATKINS, Commissioner
of the Massachusetts
Department of Public Welfare,
Petitioner,
v.
SANTOS RIVERA, Madeline McKenna,
and all others similarly situated,
Respondents.

On Writ of Certiorari to the
Supreme Judicial Court for the
Commonwealth of Massachusetts

JOINT APPENDIX

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Petition for Certiorari Filed Oct. 11, 1985
Certiorari Granted December 9, 1985

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Note: Record page references ("R. ___") within the documents set forth in this Joint Appendix are to the "Record Appendix" which was filed in the Massachusetts Appeals Court (see infra, p. 4) and was transferred to the Massachusetts Supreme Judicial Court upon the allowance of the Motion for Direct Appellate Review. The Motion for Summary Judgment was not reproduced in the "Record Appendix."

The following have been omitted from this appendix because they appear on the following pages of the appendix to the Petition for Certiorari:

Administrative Decision (Rivera), Massachusetts Department of Public Welfare (Apr. 27, 1983)	Pet. A46
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[R. 1] RELEVANT DOCKET ENTRIES

COMMONWEALTH OF MASSACHUSETTS
SUPERIOR COURT

HAMPDEN, SS. C.A. No. 83-684

Santos Rivera
v.
Charles Atkins, Commissioner of the Department of Public Welfare

1983	*	* *
May 20	2	Complaint
	*	* *
June 28	4	Answer
June 30	5	Motion of Madeline McKenna for leave to intervene as plff.
July 7	--	End. on # 5 - Allowed (Keady, J.)
	*	* *
July 20	7	Intervenor's Complaint
Aug. 3	8	Stipulation of class numerosity
Aug. 8	9	Plaintiffs' motion for class certification

Aug. 8	10	Plaintiffs' motion for summary judgment
[R. 2]		
Sept. 12	11	Answer to Intervenor's Complaint
	*	* *
Sept. 27	13	Aff't of Mathew Fishman
[Sept. 28 --		Hearing on Motions for Class Certification and for Summary Judgment (Cross, J.)]

1984

[Mar. 26]	14	Rulings on (1) Motions for (a) Class Certification and (b) Summary Judgment and (2) Order for Judgment (Cross, J.)
[R. 3]	*	* *
April 13	17	Aff't of Jolie Pillsbury
	*	* *

April 13	19	Final order judgment (Cross, J.). Notified [counsel].
	*	* *
April 13	20	Deft's Motion for Stay of Judgment Pending Appeal [filed and argued]
April 17	--	End. on # 20 - Allowed (Cross, J.)
April 24	21	Deft's motion to alter or amend judgment
May 4	22	Plffs' assent to [#21]
May 14	--	End. on # 21 - Allowed (Cross, J.)
	*	* *
May 24	24	Amended judgment (Cross, J.). Notified [counsel].
May 29	25	Deft's notice of appeal from amended judgment
	*	* *
July 6	26	Notice of Assembly of Record on Appeal

COMMONWEALTH OF MASSACHUSETTS
THE APPEALS COURT

A.C. No. 84-752

Santos Rivera
v.
Charles Atkins, Commissioner of the Department of Public Welfare

* * *

1984

2	July 16	Entered
3	Aug. 6	Parties' Joint Application for Direct Appellate Review, filed.
4	Aug. 21	Appellant's Certificate of Service (Brief and Record Appendix), filed
5	Sept. 24	Appellee's Certificate of Service (Brief), filed
-	Sept. 27	ORDER . . . of SJC Application for Direct Appellate Review - Allowed

SUPREME JUDICIAL COURT
for the
COMMONWEALTH OF MASSACHUSETTS

S.J.C. - 3667

Santos Rivera
v.
Charles Atkins, Commissioner of the Department of Public Welfare

* * *

1984

Oct. 2 ENTERED

* * *

Oct. 24 Service of Reply Brief for appellant . . .

1985

[Jan. 9 Argued]

* * *

June 12 We reverse that portion of the judgment which determined that the department violated G.L. c. 118E, § 10(5), through the application of a flat $74 disregard in determining AFDC-

related MA income eligibility, and we affirm that portion of the judgment which determined that the department's use of a six-month budget period for spend down purposes violated 42 U.S.C. § 1396(a)(10)-(C)(i)(III). We remand the matter to the Superior Court for further action consistent with the opinion.

Rescript June 12, 1985.

Reasons as on file.

* * *

July 5 MOTION For a STAY of RESCRIPT filed . . .

* * *

Aug. 5 MOTION To STAY RESCRIPT ALLOWED

Aug. 16 Petition for Rehearing filed . . .

Sept. 26 Petition for Rehearing - DENIED.

* * *

Oct. 10 ORDER. . . . Rescript stayed pending decision by U.S. Supreme Court.

[R. 4]

COMMONWEALTH OF MASSACHUSETTS
TRIAL COURT

HAMPDEN, SS. SUPERIOR COURT DEPARTMENT
HAMPDEN DIVISION
C.A. NO.

SANTOS RIVERA, individually and on behalf of all others similarly situated, Plaintiffs v. CHARLES ATKINS, as Commissioner of the Department of Public Welfare, Defendant	CLASS ACTION COMPLAINT

I. PRELIMINARY STATEMENT

Plaintiff Santos Rivera, a working mother, and her two children are being denied Medicaid benefits they sorely need and for which they would be eligible but for a statutorily unauthorized budgeting

procedure employed by the Department of Public Welfare (hereinafter Department). Ms. Rivera's income is somewhat higher than that permissible for automatic Medicaid eligibility and she therefore has, in Medicaid parlance, a "spend-down" amount that she must spend on medical services before qualifying for Medicaid. The allowable amount of income for Medicaid purposes is computed on a monthly basis. [R. 5] However, in determining the eligibility of Ms. Rivera and her children, the Department incorrectly counted her gross rather than net income, and then multiplied the resulting monthly excess (the spend-down) by six. This illegal method of calculation has created a situation in which Ms. Rivera cannot afford to acquire medical care for herself or her children.

Plaintiff seeks an order affording her, and the class she seeks to represent, a monthly spend-down, and a declaration that the Department's method of computing Medicaid eligibility contravenes the provisions of M.G.L. ch. 118E, §10(5) and 42 U.S.C. §§1396a(a)(10)-(C)(i)(III) and 1396a(a)(17).

II. JURISDICTION

2. Jurisdiction is conferred upon this Court pursuant to M.G.L. ch. 30A, ch. 231A and ch. 212, §4, which provide for judicial review of an agency action and declaratory and injunctive relief, respectively.

III. PARTIES

3. Plaintiff Santos Rivera is a citizen of the United States and resides

with her two children at 3421 Main Street, Springfield, MA, 01107.

[R. 6] 4. Defendant Charles Atkins is the Commissioner of the Department of Public Welfare for the Commonwealth of Massachusetts. Pursuant to M.G.L. ch. 18, he is responsible for the direction, supervision and control of the Department. His business address is 600 Washington Street, Boston, MA, 02111.

IV. CLASS ALLEGATIONS

5. The plaintiff brings this action on behalf of herself and all others similarly situated pursuant to Mass. R. Civ. P. 23(a) and (b). Plaintiff seeks to represent two distinct classes. The first class consists of all those medically needy working applicants for or recipients of Medicaid who have been, are being or will be subjected to the

defendant's practice of counting for Medicaid eligibility purposes their gross income without disregarding at least the amount withheld from their checks for taxes and social security payments. The second class consists of all those "AFDC-related" medically needy applicants for or recipients of Medicaid who have been, are being or will be subjected to the defendant's six-month spend-down requirement in order to qualify or requalify for Medicaid benefits.

6. The classes are so numerous that joinder of all parties is impracticable, there are questions of law and fact common to each class, the claims of the plaintiff are typical [R. 7] of those of each class, and plaintiff will fairly and adequately represent the interests of each class.

V. FACTS

THE MEDICALLY NEEDY MEDICAID PROGRAM

7. Medicaid is a cooperative federal-state cost-sharing program designed to enable each state to furnish medical assistance to blind, aged, disabled, or dependent persons whose income is insufficient to meet the costs of necessary medical services. 42 U.S.C. §1396.

8. Medicaid recipients in Massachusetts receive an identification card from the Department to verify their participation in the program and to provide access to medical care.

9. Providers of medical services bill and receive payment from the Department for any covered services furnished to eligible persons presenting identification cards.

10. The Department has established a program, pursuant to 42 U.S.C. §1396a(a)(10), under which individuals and families who meet the status requirements for eligibility for either AFDC or Supplemental Security Income (SSI), but who have too much income to qualify them for cash assistance grants, may still qualify for Medicaid if their medical expenses consume their "excess" income. People who qualify for medical assistance in this manner are known as the "medically needy".

[R. 8] 11. The amount of a medically needy individual's income which is designated as "excess" by the Department and which must be spent on medical care prior to qualifying for Medicaid is called a "spend-down".

12. In order to determine the amount of a person's spend-down, the Department

compares his/her monthly income to a monthly income standard table. The amount of income above the listed standard is then multiplied by six and the resulting number represents the person's spend-down.

13. Under the Department's system of calculation, an applicant or recipient is therefore required to spend for medical services six times his/her monthly excess before (s)he is determined to be eligible for Medicaid.

14. After medical expenses have been incurred in an amount equal to the spend-down, a Medicaid card is issued and eligibility is established for the remainder of the period of six months from the date the spend-down began.

15. At the end of this six-month period, the recipient is terminated from Medicaid and must spend down according

to the formula described above to regain eligibility.

16. In computing the amount of income that a working applicant for or recipient of Medicaid has available, the Department counts that person's gross income, without deducting the amount withheld from each check for taxes and social security payments.

[R. 9] 17. Eligibility for persons applying for or receiving AFDC is determined by measuring the income received by an individual or family in a single month against the cash assistance standard for one month. 42 U.S.C. 602(a)-(13).

18. Pursuant to 42 U.S.C. §1396a(a)(10)(C)(i)(III), added to Title XIX of the Social Security Act by the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, when a state chooses to

provide benefits to the medically needy, as Massachusetts has done, its state Medicaid plan must set forth:

> (III) the single standard to be employed in determining income and resource eligibility... and the methodology to be employed in determining such eligibility, ... which shall be the same methodology which would be employed under the appropriate State plan (described in subparagraph (A)(i) [i.e., SSI or AFDC] to which such group is most closely categorically related... (emphasis added)

19. In determining eligibility for medical assistance, a state is required by 42 U.S.C. §1396a(a)(17) to:

> ... include reasonable standards (which shall be comparable for all groups...) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and... (C) provide

> for reasonable evaluation of any such income or resources, ...

[R. 10] 20. Pursuant to 42 Code of Federal Regulations §435.831, a state "must use a prospective period of not more than 6 months to compute income."

THE PLAINTIFF

21. Santos Rivera works full-time for the John R. Lyman Co. in Chicopee, Mass. and grosses $152.00 per week, of which, after withholdings for taxes and social security payments, she takes home $128.20.

22. Ms. Rivera receives no medical benefits from her job, either for herself or her two minor children.

23. Because Ms. Rivera's income is slightly too "high" to qualify her family automatically for Medicaid, she is considered an AFDC-related medically needy individual.

24. Ms. Rivera applied for Medicaid on January 13, 1983, but was denied benefits on February 13, 1983 because the Department determined that her family had "excess" income of $100.30 per month.

25. Because of her excess income, Ms. Rivera was told by the Department that she had to spend $601.80 (her monthly excess times six) on medical needs before her family would qualify for Medicaid.

26. In the month of February, 1983, Ms. Rivera incurred hospital bills of $314.00, an amount equal to almost half of her monthly income, but the Department would pay no part of those charges due to its six month spend-down policy. [R. 11] 27. Ms. Rivera has virtually no savings, and certainly nowhere near

enough to meet the $601.80 spend-down imposed by the Department.

28. On March 28, 1983, Ms. Rivera appealed the Department's refusal to provide her family with Medicaid, and a hearing was held on April 14, 1983.

29. By decision dated April 27, 1983 (annexed hereto as Exhibit A), the Department's hearing officer upheld the defendant's method of counting earned income and of computing a person's spend-down. Ms. Rivera's appeal was therefore denied.

VI. LEGAL CLAIMS

30. Defendant's policy and practice of counting the gross income of working applicants for or recipients of Medicaid without disregarding the amounts withheld from such persons' checks for taxes and social security payments violates M.G.L. ch. 118E, §10(5).

31. Defendant's policy and practice of using a six month period for calculating the income of AFDC-related medically needy applicants for and recipients of Medicaid violates 42 U.S.C. §1396a(a)(10)(C)(i)(III) insofar as it employs a different budgeting methodology to determine their Medicaid eligibility than is used to determine eligibility for the AFDC program.

[R. 12] 32. Defendant's policy and practice of using a six month period for calculating the income of AFDC-related medically needy applicants for and recipients of Medicaid violates 42 U.S.C. §1396a(a)(17) because it utilizes a standard for determining eligibility which:

(a) is not comparable to that used to determine AFDC eligibility;

(b) is not reasonable;

(c) is not consistent with the objectives of the Medicaid Act;

(d) does not provide for reasonable evaluation of income and resources.

33. Defendant's policy and practice, to the extent it denies plaintiff rights secured by 42 U.S.C. §§1396a(a)(10)-(C)(i)(III) and 1396a(a)(17), violates 42 U.S.C. §1983.

VII. PRAYER FOR RELIEF

WHEREFORE, plaintiff respectfully prays that this Court:

1. Certify this case as a proper class action;

2. Declare that the defendant's policy and practice of using a six month period for calculating the income of "AFDC-related" medically needy applicants for and recipients of Medicaid violates

42 U.S.C. §§1396a(a)(10)(C)(i)(III) and 1396a(a)(17), and thereby 42 U.S.C. §1983.

[R. 13] 3. Declare that defendant's policy and practice of counting all of the earnings of a working applicant for or recipient of Medicaid without disregarding amounts withheld for taxes and social security payments violates M.G.L. ch. 118E, §10(5);

4. Permanently enjoin the defendant from:

(a) using a longer period for calculating the income of "AFDC-related" medically needy applicants for and recipients of Medicaid than is used for purposes of determining eligibility for the AFDC program; and

(b) including as countable income for Medicaid purposes amounts withheld for taxes and social security payments from the checks of working applicants for or recipients of Medicaid.

5. Grant plaintiffs the cost of this action, including reasonable attorney's fees pursuant to 42 U.S.C. §188; and

6. Grant such other and further relief as the Court deems just and appropriate.

s/
Steven A. Hitov
Western Mass. Legal Services
145 State Street
Springfield, MA 01103
(Tel. (413) 781-7814

Dated: May 17, 1983

[Exhibit A to the Complaint, the Administrative Decision of the Massachusetts Department of Public Welfare, Division of Hearings, is reproduced at Pet. A46-A53.]

[R. 16]

COMMONWEALTH OF MASSACHUSETTS
TRIAL COURT

HAMPDEN, SS. SUPERIOR COURT
C.A. NO. 83-684

SANTOS RIVERA,

Plaintiff

v.

CHARLES ATKINS,

Defendant

ANSWER

The defendant Charles M. Atkins, as Commissioner of the Department of Public Welfare, answers the plaintiff's Complaint as follows:

FIRST DEFENSE

To the extent that the Complaint is based upon Mass. G.L. c. 30A, the defendant submits attached hereto a certified

copy of the record of the administrative proceedings, pursuant to Mass. G.L. c. 30A, § 14(4).

SECOND DEFENSE

To the extent that the Complaint purports to be brought other than pursuant to c. 30A, it fails to state a claim upon which relief may be granted.

THIRD DEFENSE

The defendant answers the numbered paragraphs of the plaintiff's Complaint as follows:

[R. 17] **Preliminary Statement**

1. The "preliminary statement" is a characterization of the action replete with legal conclusions, and therefore requires no response, and otherwise is denied.

Jurisdiction

2. The defendant admits that this Court has jurisdiction pursuant to c. 30A, and denies the remaining allegations of paragraph two of the Complaint.

Parties

3. The defendant lacks knowledge or information sufficient to form a belief as to the truth of the allegations contained in paragraph three of the Complaint.

4. Admitted.

Class Allegations

5. The defendant admits that the plaintiff seeks to bring this action as a class action, but denies that there is any legal or factual basis therefor. Except as admitted herein, the defendant denies the allegations contained in paragraph five of the Complaint.

6. Denied.

The Medically Needy Medicaid Program

7. The allegations contained in paragraph seven of the Complaint are conclusions of law requiring no response.

8. Admitted.

9. Admitted.

[R. 18] 10. The defendant admits that the Department has undertaken to provide Medical Assistance, at its option under 42 U.S.C. § 1396a(a)(10), to certain individuals and families who do not qualify for AFDC or SSI, as more particularly set forth and defined in various statutes and regulations, which speak for themselves. Except as admitted herein, the defendant denies the allegations contained in paragraph ten of the Complaint.

11-16. The defendant says that the allegations of paragraphs eleven through

sixteen of the Complaint are characterizations of the requirements of statutes and regulations defining and governing the defendant's provision of Medical Assistance to certain families and individuals who do not qualify for AFDC or SSI, and that such statutes and regulations speak for themselves. Except as admitted herein, the defendant denies the allegations contained in paragraphs eleven through sixteen of the Complaint.

17. The allegations contained in paragraph seventeen of the Complaint are conclusions of law requiring no response, and otherwise are denied.

18. 42 U.S.C. § 1396a(a)(10)(C)-(i)(III), as amended by the Tax Equity and Fiscal Responsibility Act of 1982 is a writing which speaks for itself.

19. 42 U.S.C. § 1396a(a)(17) is a writing which speaks for itself.

[R. 19] 20. 42 C.F.R. § 435.831 is a writing which speaks for itself.

The Plaintiff

21-29. Except as established by the administrative record and decision attached hereto, the Department lacks knowledge or information sufficient to form a belief as to the truth of the allegations contained in paragraphs twenty-one through twenty-nine of the Complaint.

Legal Claims

30. Denied.

31. Denied.

32. Denied.

33. Denied.

FOURTH DEFENSE

The defendant says that the regulations and practices challenged by the

Complaint comport with federal and state law, to the extent applicable.

By his attorneys,

FRANCIS X. BELLOTTI
ATTORNEY GENERAL

s/_____
H. Reed Witherby
Assistant Attorney General
Government Bureau
One Ashburton Place, Room 2019
Boston, Massachusetts 02108
(617) 727-1020

Date: June 27, 1983

[The certified copy of the Administrative Record which was attached to the Answer is reproduced at R. 20-75.]

[R. 76]

COMMONWEALTH OF MASSACHUSETTS
TRIAL COURT

HAMPDEN, SS. SUPERIOR COURT DEPARTMENT
HAMPDEN DIVISION
C.A. No. 83-684

MADELINE MCKENNA, Plaintiff v. CHARLES ATKINS, as Commissioner of the Department of Public Welfare, Defendant	INTERVENOR'S COMPLAINT

I. PRELIMINARY STATEMENT

Plaintiff Madeline McKenna, a working mother, and her child are being denied Medicaid benefits they sorely need and for which they would be eligible but for a statutorily unauthorized budgeting procedure employed by the Department of Public Welfare (hereinafter Department).

Ms. McKenna's income is somewhat higher than that permissible for automatic Medicaid eligibility and she therefore has, in Medicaid parlance, a "spend-down" amount that she must spend on medical services before qualifying for Medicaid. The allowable amount of income for Medicaid purposes is computed on a monthly basis. [R. 77] However, in determining the eligibility of Ms. McKenna and her child, the Department incorrectly counted her gross rather than net income, and then multiplied the resulting monthly excess (the spend-down) by six. This illegal method of calculation has created a situation in which Ms. McKenna cannot afford to acquire medical care for herself or her child.

Plaintiff seeks an order affording her a monthly spend-down, and a decla-

ration that the Department's method of computing Medicaid eligibility contravenes the provisions of M.G.L. ch. 118E, §10(5) and 42 U.S.C. §§1396a(a)(10)(C)-(i)(III) and 1396a(a)(17).

II. JURISDICTION

2. Jurisdiction is conferred upon this Court pursuant to M.G.L. ch. 30A, ch. 231A and ch. 212, §4, which provide for judicial review of an agency action and declaratory and injunctive relief, respectively.

III. PARTIES

3. Plaintiff Madeline McKenna is a citizen of the United States and resides with her child at 14 Palmer Road, Three Rivers, MA 01080.

[R. 78] 4. Defendant Charles Atkins is the Commissioner of the Department of

Public Welfare for the Commonwealth of Massachusetts. Pursuant to M.G.L. ch. 18, he is responsible for the direction, supervision and control of the Department. His business address is 600 Washington Street, Boston, MA, 02111.

IV. FACTS

THE MEDICALLY NEEDY MEDICAID PROGRAM

5. Medicaid is a cooperative federal-state cost-sharing program designed to enable each state to furnish medical assistance to blind, aged, disabled, or dependent persons whose income is insufficient to meet the costs of necessary medical services. 42 U.S.C. §1396.

6. Medicaid recipients in Massachusetts receive an identification card from the Department to verify their participation in the program and to provide access to medical care.

7. Providers of medical services bill and receive payment from the Department for any covered services furnished to eligible persons presenting identification cards.

8. The Department has established a program, pursuant to 42 U.S.C. §1396a(a)(10), under which individuals and families who meet the status requirements for eligibility for either AFDC or Supplemental Security Income (SSI), but who have too [R. 79] much income to qualify them for cash assistance grants, may still qualify for Medicaid if their medical expenses consume their "excess" income. People who qualify for medical assistance in this manner are known as the "medically needy".

9. The amount of a medically needy individual's income which is designated

as "excess" by the Department and which must be spent on medical care prior to qualifying for Medicaid is called a "spend-down".

10. In order to determine the amount of a person's spend-down, the Department compares his/her monthly income to a monthly income standard table. The amount of income above the listed standard is then multiplied by six and the resulting number represents the person's spend-down.

11. Under the Department's system of calculation, an applicant or recipient is therefore required to spend for medical services six times his/her monthly excess before (s)he is determined to be eligible for Medicaid.

12. After medical expenses have been incurred in an amount equal to the spend-

down, a Medicaid card is issued and eligibility is established for the remainder of the period of six months from the date the spend-down began.

13. At the end of this six-month period, the recipient is terminated from Medicaid and must spend down according to the formula described above to regain eligibility.

[R. 80] 14. In computing the amount of income that a working applicant for or recipient of Medicaid has available, the Department counts that person's gross income, without deducting the amount withheld from each check for taxes and social security payments.

15. Eligibility for persons applying for or receiving AFDC is determined by measuring the income received by an individual or family in a single month

against the cash assistance standard for one month. 42 U.S.C. 602(a)(13).

16. Pursuant to 42 U.S.C. §1396a(a)(10)(C)(i)(III), added to Title XIX of the Social Security Act by the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, when a state chooses to provide benefits to the medically needy, as Massachusetts has done, its state Medicaid plan must set forth:

> (III) the single standard to be employed in determining income and resource eligibility... and the methodology to be employed in determining such eligibility, ... which shall be the same methodology which would be employed under the appropriate State plan (described in subparagraph (A)(i) [i.e., SSI or AFDC] to which such group is most closely categorically related... (emphasis added)

17. In determining eligibility for medical assistance, a state is required by 42 U.S.C. §1396a(a)(17) to:

> ... include reasonable standards (which shall be comparable for all groups...) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this [R. 81] subchapter, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the ap- plicant or recipient and... (C) provide for reasonable evaluation of any such income or resources, ...

18. Pursuant to 42 Code of Federal Regulations §435.831, a state "must use a prospective period of not more than 6 months to compute income."

THE PLAINTIFF

19. On September 11, 1982 Madeline McKenna began work full-time for Pioneer Valley Plastics Co., Three Rivers, MA and currently grosses $140.00 per week, of which, after withholdings for taxes

and social security payments, she takes home $106.89.

20. Ms. McKenna receives no medical benefits from her job, either for herself or her child.

21. Because Ms. McKenna's income is slightly too "high" to qualify her family automatically for Medicaid, she is considered an AFDC-related medically needy individual.

22. Prior to starting work, Ms. McKenna received AFDC benefits to support herself and her family. As a result of her earnings from her job, the AFDC benefits were terminated in December of 1982 but Medicaid benefits continued for four months in accordance with 106 C.M.R. 504.110.

[R. 82] 23. On April 31, 1983 the McKenna family's Medicaid benefits

stopped. Ms. McKenna reapplied for Medicaid but was denied because of "excess" income of $106.66 per month.

24. Because of her excess income, Ms. McKenna was told by the Department that she had to spend $639.96 (her monthly excess times six) on medical needs before her family would qualify for Medicaid.

25. Ms. McKenna has virtually no savings, and certainly nowhere near enough to meet the $639.96 spend-down imposed by the Department.

26. On April 18, 1983, Ms. McKenna appealed the Department's refusal to provide her family with Medicaid, and a hearing was held in front of a Department referee.

27. By decision dated June 7, 1983 (annexed hereto as Exhibit A), the De-

partment's appeals referee upheld the defendant's method of counting earned income and of computing a person's spend-down. Ms. McKenna's appeal was therefore denied.

VI. LEGAL CLAIMS

28. Defendant's policy and practice of counting the gross income of working applicants for or recipients of Medicaid without disregarding the amounts withheld from such persons' checks for taxes and social security payments violates M.G.L. ch. 118E, §10(5).

[R. 83] 29. Defendant's policy and practice of using a six month period for calculating the income of AFDC-related medically needy applicants for and recipients of Medicaid violates 42 U.S.C. §1396a(a)(10)(C)(i)(III) insofar as it

employs a different budgeting methodology to determine their Medicaid eligibility than is used to determine eligibility for the AFDC program.

30. Defendant's policy and practice of using a six month period for calculating the income of AFDC-related medically needy applicants for and recipients of Medicaid violates 42 U.S.C. §1396a(a)(17) because it utilizes a standard for determining eligibility which:

(a) is not comparable to that used to determine AFDC eligibility;

(b) is not reasonable;

(c) is not consistent with the objectives of the Medicaid Act;

(d) does not provide for reasonable evaluation of income and resources.

31. Defendant's policy and practice, to the extent it denies plaintiff rights

secured by 42 U.S.C. §§1396a(a)(10)(C)-(i)(III) and 1396a(a)(17), violates 42 U.S.C. §1983.

[R. 84] VI. PRAYERS FOR RELIEF

WHEREFORE, plaintiff respectfully prays that this Court:

1. Declare that the defendant's policy and practice of using a six month period for calculating the income of "AFDC-related" medically needy applicants for and recipients of Medicaid violates 42 U.S.C. §§1396a(a)(10)(C)(i)(III) and 1396a(a)(17), and thereby 42 U.S.C. §1983.

2. Declare that defendant's policy and practice of counting all of the earnings of a working applicant for or recipient of Medicaid without disregarding amounts withheld for taxes and social

security payments violates M.G.L. ch. 118E, §10(5);

3. Permanently enjoin the defendant from:

(a) using a longer period for calculating the income of "AFDC-related" medically needy applicants for and recipients of Medicaid than is used for purposes of determining eligibility for the AFDC program; and

(b) including as countable income for Medicaid purposes amounts withheld for taxes and social security payments from the checks of working applicants for or recipients of Medicaid.

4. Grant plaintiff the cost of this action, including reasonable attorney's fees pursuant to 42 U.S.C. §1988; and

[R. 85] 5. Grant such other and further relief as the Court deems just and appropriate.

s/_____
Suzanne Harris
Western Mass. Legal Services
145 State Street
Springfield, MA 01103
Tel. (413) 781-7814

Dated: June 29, 1983

[Exhibit A to the Intervenor's Complaint, the Administrative Decision of the Massachusetts Department of Public Welfare, Division of Hearings, is reproduced at Pet. A54-A60.]

[R. 88]

COMMONWEALTH OF MASSACHUSETTS

HAMPDEN, SS. SUPERIOR COURT
C.A. No. 83-684

SANTOS RIVERA, et al.,

Plaintiffs

v.

CHARLES ATKINS,

Defendant

ANSWER TO INTERVENOR'S COMPLAINT

The defendant Charles M. Atkins, as Commissioner of the Department of Public Welfare, answers the Complaint of Intervenor Madeline McKenna as follows:

FIRST DEFENSE

To the extent that the Complaint is based upon Mass. G.L. c. 30A, the defendant submits attached hereto a certified

copy of the record of the administrative proceedings, pursuant to Mass. G.L. c. 30A, § 14(4).

SECOND DEFENSE

To the extent that the Complaint purports to be brought other than pursuant to c. 30A, it fails to state a claim upon which relief may be granted.

THIRD DEFENSE

The defendant answers the numbered paragraphs of the Intervenor's Complaint as follows:

[R. 89] Preliminary Statement

1. The "preliminary statement" is a characterization of the action replete with legal conclusions, and therefore requires no response, and otherwise is denied.

Jurisdiction

2. The defendant admits that this Court has jurisdiction pursuant to c. 30A, and denies the remaining allegations of paragraph two of the Complaint.

Parties

3. The defendant lacks knowledge or information sufficient to form a belief as to the truth of the allegations contained in paragraph three of the Complaint.

4. Admitted.

The Medically Needy Medicaid Program

5. The allegations contained in paragraph five of the Complaint are conclusions of law requiring no response.

6. Admitted.

7. Admitted.

8. The defendant admits that the Department has undertaken to provide Medical Assistance, at its option under 42

U.S.C. § 1396a(a)(10), to certain individuals and families who do not qualify for AFDC or SSI, as more particularly set forth and defined in various statutes and regulations, which speak for themselves. Except as admitted herein, the defendant denies the allegations contained in paragraph eight of the Complaint.

[R. 90] 9-14. The defendant says that the allegations of paragraphs nine through fourteen of the Complaint are characterizations of the requirements of statutes and regulations defining and governing the defendant's provision of Medical Assistance to certain families and individuals who do not qualify for AFDC or SSI, and that such statutes and regulations speak for themselves. Except as admitted herein, the defendant denies

the allegations contained in paragraphs nine through fourteen of the Complaint.

15. The allegations contained in paragraph fifteen of the Complaint are conclusions of law requiring no response, and otherwise are denied.

16. 42 U.S.C. § 1936a(a)(10)(C)-(i)(III), as amended by the Tax Equity and Fiscal Responsibility Act of 1982 is a writing which speaks for itself.

17. 42 U.S.C. § 1396a(a)(17) is a writing which speaks for itself.

18. 42 C.F.R. § 435.831 is a writing which speaks for itself.

The Plaintiff

19-27. Except as established by the administrative record and decision attached hereto, the Department lacks knowledge or information sufficient to form a belief as to the truth of the allegations contained in paragraph nineteen

through twenty-seven of the Complaint.

[R. 91] Legal Claims

28. Denied.

29. Denied.

30. Denied.

31. Denied.

FOURTH DEFENSE

The defendant says that the regulations and practices challenged by the Complaint comport with federal and state law, to the extent applicable.

By his attorneys,

FRANCIS X. BELLOTTI
ATTORNEY GENERAL

s/
H. Reed Witherby
Assistant Attorney General
Government Bureau
One Ashburton Place, Room 2019
Boston, Massachusetts 02108
(617) 727-1020

Date: Sept. 9, 1983

[The certified copy of the Administrative Record which was attached to the Answer to Intervenor's Complaint is reproduced at R. 92-129.]

COMMONWEALTH OF MASSACHUSETTS

HAMPDEN, SS. SUPERIOR COURT
C.A. No. 83-684

SANTOS RIVERA, ET AL. Plaintiffs V. CHARLES ATKINS, Defendant	MOTION FOR SUMMARY JUDGMENT

Plaintiffs move this Court for an order of summary judgment in their favor in this case upon the grounds that there are no material issues of fact in dispute and that plaintiffs are entitled to such relief as a matter of law, as is more fully set out in their memorandum submitted herewith.

PLAINTIFFS,

By their attorney,

s/_____

Steven A. Hitov
Western Massachusetts
Legal Services, Inc.
145 State Street
Springfield, MA 01103
(413) 781-7814

August 4, 1983

Supreme Court, U.S.
FILED
FEB 1 1986
JOSEPH F. SPANIOL, JR.
CLERK

No. 85-632

IN THE
SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1985

CHARLES ATKINS, Commissioner
of the Massachusetts
Department of Public Welfare,

Petitioner,

v.

SANTOS RIVERA, Madeline McKenna,
and all others similarly situated,

Respondents.

On Writ of Certiorari
to the Supreme Judicial Court for
the Commonwealth of Massachusetts

BRIEF FOR THE PETITIONER

FRANCIS X. BELLOTTI
ATTORNEY GENERAL

H. Reed Witherby
Counsel of Record
Assistant Attorney General
Government Bureau
One Ashburton Place, Room 2019
Boston, Massachusetts 02108
(617) 727-1020

January 1986

QUESTION PRESENTED

Whether Massachusetts' use of a six-month spenddown period for medically needy Medicaid eligibility, which has been authorized by federal regulation consistently since the inception of the Medicaid program in 1966 and also is employed by most states which extend Medicaid coverage to the medically needy, violates Title XIX of the Social Security Act, as amended by the Tax Equity and Fiscal Responsibility Act of 1982.

PARTIES

The respondent class is composed of all AFDC-related medically needy applicants for or recipients of Medicaid in Massachusetts subject to a six-month spenddown. All other parties are named in the caption.

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No. 85-632

IN THE
SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1985

CHARLES ATKINS, Commissioner
of the Massachusetts
Department of Public Welfare,

Petitioner,

v.

SANTOS RIVERA, Madeline McKenna,
and all others similarly situated,

Respondents.

On Writ of Certiorari
to the Supreme Judicial Court for
the Commonwealth of Massachusetts

BRIEF FOR THE PETITIONER

OPINIONS BELOW

The opinion of the Supreme Judicial Court (Pet. A1) is reported at 395 Mass. 189 and 479 N.E.2d 639. The opinion of the state trial court (Pet. A28) and the administrative decisions of the state

Department of Public Welfare (Pet. A46, A54) are not reported.

JURISDICTION

The jurisdiction of this Court rests upon 28 U.S.C. § 1257(3). The order (Pet. A61) and rescript of the Supreme Judicial Court, the highest court of the Commonwealth of Massachusetts, were entered on June 12, 1985. J.A. 5-6. On August 21, 1985, Justice Brennan extended the time in which to petition for certiorari to October 15, 1985 (Supreme Court docket no. A-147). The Commissioner's petition for rehearing in the Supreme Judicial Court was denied on September 26, 1985. Pet. A63; J.A. 7. The petition for certiorari was filed on October 11, 1985, and was granted on December 9, 1985.

STATUTES INVOLVED

This case involves the construction of 42 U.S.C. § 1396a(a)(10)(C)(i)(III) (1982 ed.), inserted by the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA"), P.L. 97-248, § 137(b)(8), 96 Stat. 378, which provides that a State choosing to extend Medicaid coverage to medically needy groups must, in its state plan, describe:

> (III) the single standard to be employed in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligibility, which shall be the same methodology which would be employed under the supplemental security income program in the case of groups consisting of aged, blind, or disabled individuals in a State in which such program is in effect, and which shall be the same methodology which would be employed under the appropriate State plan (described in subparagraph (A)(i)) to which such group is most closely categorically related in the case of other groups; . . . (emphasis added)

The decision below held that the emphasized language requires a one-month "spenddown" in determining medically needy Medicaid eligibility and, on that ground, held invalid Mass. Gen. Laws ch. 118E, § 10, fourth unnumbered paragraph (1984 ed.), which provides:

> In any case where the monthly income of a recipient or beneficiary is in excess of the exemptions allowed, the recipient or beneficiary shall be liable to pay to the provider of medical care or service an amount which shall be equal to the excess income for a period of six consecutive months, which includes the period when such service was provided. (emphasis added)

The spenddown concept derives from 42 U.S.C. § 1396a(a)(17), which provides that the state Medicaid plan must:

> include reasonable standards . . . for determining eligibility . . .; and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the

> Secretary, the costs (whether in the form of insurance premiums or otherwise) incurred for medical care or for any other type of remedial care recognized under State law[.] (emphasis added)

42 C.F.R. § 435.831 (1985) provides:

> The [state Medicaid] agency must determine income eligibility of medically needy individuals in accordance with this section. The agency must use a prospective period of not more than 6 months to compute income. . . . (emphasis added)

The full text of these and other relevant statutes and regulations is set forth in the appendix to this brief.

STATEMENT OF THE CASE

1. Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 et seq., was enacted in 1965 to enable states, "as far as practicable under the conditions in such State," to provide medical assistance ("Medicaid") to needy families with

children and aged, blind or disabled individuals. 42 U.S.C. § 1396. Participating states must provide coverage to all those who receive cash assistance under either of the two major federal categorical welfare programs: Aid to Families with Dependent Children (AFDC), 42 U.S.C. §§ 601 et seq.; and Supplemental Security Income (SSI), 42 U.S.C. §§ 1381 et seq. See 42 U.S.C. § 1396a-(a)(10)(A)(i).[1/] These groups are referred to as the "categorically needy." 42 C.F.R. § 435.4 (1985). Congress required such coverage for participating

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1/ The so-called "§ 209(b) option" creates an exception to this requirement as to SSI recipients in states which choose to use instead the standards of their former categorical assistance plans for the aged, blind and disabled as of January 1, 1972. See 42 U.S.C. § 1396a(f); Schweiker v. Gray Panthers, 453 U.S. 34, 37-39 (1981). Massachusetts is not a § 209(b) state.

states because "[t]hese people are the most needy in the country and it is appropriate for medical care costs to be met, first, for these people." H.R. Rep. No. 213, 89th Cong., 1st Sess. 66 (1965).[2/]

A participating state also has the option of extending coverage to other, "less needy," groups, id., who are referred to as the "medically needy" -- families and individuals who would qualify for AFDC or SSI except for their income or resources, but whose income and resources are insufficient to meet the costs of necessary medical and remedial care and services. 42 U.S.C. § 1396a(a)-

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2/ Eligibility for the categorical programs of cash assistance is determined on a monthly basis. See 42 U.S.C. §§ 602(a)(13) (AFDC); 42 U.S.C. § 1382(c)(1) (SSI).

(10)(C); 42 C.F.R. § 435.4.[3/] See generally, Schweiker v. Hogan, 457 U.S. 569, 571-76 (1982).

Massachusetts has chosen to participate in Medicaid and to extend coverage to the "medically needy". Mass. Gen Laws ch. 118E, § 1 (1984 ed.).[4/]

3/ The 1981 amendment to 42 U.S.C. § 1396a(a)(10)(C)(i) appears to some extent to have relaxed the link between the definition of the medically needy and the underlying categorical programs. See pp. 40-41, infra (detailing the statutory change); but see 42 U.S.C. § 1396a(a)(10)(C)(ii) (1982 ed.).

4/ For the Court's convenience, the petitioner is lodging with the Clerk copies of relevant portions of the state Medicaid financial eligibility regulations, 106 Code of Massachusetts Regulations ("C.M.R."), Parts 505 and 506. The principal relevant spenddown regulations are also reproduced in the Appendix to this brief.

Massachusetts determines financial eligibility for a medically needy applicant in a straightforward manner.[5/] First, gross countable income is calculated.[6/] Then, various deductions are subtracted, to determine the applicant's

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5/ The references in the following discussion apply to applicants other than those who are in long-term institutional care. Different rules in certain respects apply to institutional residents, due to their unique situation. See R. 162-63 (HHS explanation); Williams v. St. Clair, 610 F.2d 1244 (5th Cir. 1980) (upholding the anticipation of medical costs for such persons). These differences have never been involved in this litigation and are immaterial to the issue presented.

6/ See 106 C.M.R. §§ 505.200 (Income), 505.210 (Countable Earned Income) 505.220 (Countable Unearned Income). Some income that is actually received is not counted in determining eligibility. Id. § 505.230 (Non-Countable Income).

net countable income. 42 C.F.R. § 435.831(a).[7] The net countable income figure is then compared with the Medicaid income standard.[8] If the applicant's net countable income is equal to or less than the income standard, the applicant is eligible for Medicaid coverage. 42 C.F.R. § 435.831(b); 106 C.M.R. § 506.400.[9]

7/ See 106 C.M.R. §§ 506.110 (Unearned Income Deductions), 506.120 (Earned Income Deductions), 506.130 (General Income Deductions).

8/ This is the "single [income] standard" of 42 U.S.C. § 1396a(a)(10)(C)(i)-(III). See 106 C.M.R. § 506.410.

9/ It is uncontested that in this process of determining countable income for measurement against the Medicaid income standard, Massachusetts uses the same methodology which would be employed in determining the applicant's eligibility for the most closely related categorical program, i.e., AFDC for the respondent class in this case, and SSI for the SSI-related medically needy class in Hogan v. Heckler, 769 F.2d 886 (1st Cir. 1985).

The respondents do not qualify for Medicaid on this basis, however, because their net countable income exceeds the Medicaid income standard. The determination of their Medicaid eligibility involves an extra factor, not considered for categorically needy eligibility: they may become eligible if they incur medical expenses equal to their "excess income" (i.e., the amount by which their net countable income exceeds the Medicaid income standard). 42 U.S.C. § 1396a(a)-(17); 42 C.F.R. § 435.831(c)-(d); 106 C.M.R. §§ 506.500 et seq. The amount of medical bills that must thus be incurred is known as a "spenddown."10/

10/ This term is somewhat misleading. The applicant is only required to incur the expense, and need not have actually paid the bill for medical services. 42 U.S.C. §§ 1396a(a)(17), 1396b(f)(2); 42 C.F.R. § 435.831(c)-(d); 106 C.M.R. § 506.540.

2. The Secretary of Health and Human Services ("HHS"), and before him the Secretary of Health, Education and Welfare ("HEW"), have permitted a spenddown period of up to six months since the inception of the Medicaid program in 1966.[11/] In reliance upon the Secretary's regulations, 25 of the 32 jurisdictions participating in the medically needy program at the time of the TEFRA amendment at issue in this case used a spenddown period of greater than one

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11/ Department of Health, Education and Welfare, Handbook of Public Assistance Administration, Supplement D, Section D-4220(A)(4) (June 17, 1966), now codified at 42 C.F.R. § 435.831 (1985) (both reproduced in the Appendix to this brief); see DeJesus v. Perales, 770 F.2d 316, 322-23 and n. 8 (2d Cir. 1985); Hogan v. Heckler, 769 F.2d 886, 893 (1st Cir. 1985); see also n. 33, infra.

month.[12] Twenty used six months.[13]

Massachusetts is one of those states. Mass. Gen. Laws ch. 118E, § 10, fourth unnumbered paragraph, inserted by Mass. St. 1969, c. 800, requires the calcula-

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12/ These figures are derived from interrogatory answers filed by the Secretary in October 1983 in Hogan v. Heckler, No. 80-883-T (U.S.D.C., D. Mass.), which were submitted below in this case at the summary judgment stage and are reproduced at R. 152-168; see esp. R. 168 (table). The petitioner is unaware of any changes between the enactment of TEFRA in September 1982 and the date of this document (except the adoption by the State of Washington of multiple budget periods, see R. 161). Several states have adopted medically needy programs more recently. See n. 29, infra.

13/ Two of the 20, however, afforded the recipient a choice between six months and either one month (Illinois) and three months (Washington). R. 168. Although Nebraska is also listed as having multiple periods, this was not at the recipient's option; the one-month period applied only to a limited category of individuals. See R. 161.

tion of excess income over a six-month period to arrive at the spenddown amount. See 106 C.M.R. §§ 506.510, 506.520 (implementing this statutory command).[14/] Once the applicant incurs medical bills equal to the amount of the spenddown, Medicaid pays for all other covered services during the spenddown period. See 106 C.M.R. § 506.570.[15/]

3. Ms. Rivera applied for Medicaid on January 13, 1983. Pet. A50. A hearing officer determined after an administrative hearing (R. 20-75) that her net

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14/ Massachusetts regulations more generally provide for the use of six-month budget period, see 106 C.M.R. § 505.300, although income is converted to monthly amounts before being used in eligibility calculations, id. § 505.320.

15/ If the applicant's income changes during the six-month period, adjustments are made accordingly. 106 C.M.R. § 506.560.

countable income was $535.30 per month. Pet. A51.[16] At that time the standard of need for a family of 3 (Ms. Rivera and her 2 children) was $435 per month;[17] Ms. Rivera thus had income of $100.30 per month in excess of the income standard. Pet. A51. It followed that she had a six-month spenddown liability of $601.80 (6 x $100.30). J.A. 19 (Complaint, ¶ 25); Pet. A51. But she argued that the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA"), P.L. 97-248, § 137(b)(8), 96 Stat. 378,

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16/ The findings of fact by the administrative hearing officer are final unless unsupported by substantial evidence. Mass. Gen. Laws ch. 30A, § 14. In this case, the administrative findings (see Pet. A50-A51, A57-A59) were not disputed in the Superior Court.

17/ The applicable standard has since been increased. The current level is set forth in 106 C.M.R. § 506.410 (December 1985).

required her spenddown to be calculated on a monthly basis. R. 40-42. Ms. Rivera claimed that the Department should pay the difference between her excess income for one month ($100.30) and medical bills incurred in that one month totalling $314.00. J.A. 19 (Complaint, ¶ 26).[18]

Under the six-month spenddown, Ms. Rivera and persons similarly situated must budget the payment of medical expenses over a period longer than one month, up to an amount equalling six months' excess income. The six-month

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18/ The intervenor-plaintiff, Ms. McKenna, unlike Ms. Rivera, had regular dental expenses of $70 a month (with no other medical expenses) which were less than her excess income of $106.66 a month. See R. 96-97; J.A. 40-43. For this reason, her eligibility would not appear actually to have been affected by the length of the spenddown period applied to her.

spenddown focuses the state's resources instead upon another group of applicants who are in greater need. An applicant whose excess income is $100/month and whose medical expenses exceed $600 in a six-month period is more needy than another applicant (such as Ms. Rivera) with the same income but with medical expenses of only $314 over six months -- even if the entire $314 happens to be incurred in one month. In short, the six-month spenddown allocates scarce welfare resources to the neediest of potentially eligible applicants.[19/]

19/ Massachusetts couples this policy with a high standard of income eligibility and a wide range of covered medical services. See Department of Health and Human Services, Medicare and Medicaid Data Book, 1981 (April, 1982) at 78, 105, 106, 111; Committee Print No. 10, 95th Cong., 1st Sess., "Data on the Medicaid Program: Eligibility, Services, Expenditures, Fiscal Years 1966-77," at 6, 9, 86-87.

4. The complaint was brought in May 1983 in the Massachusetts Superior Court against the Massachusetts Commissioner of Public Welfare ("Commissioner"), as a class action challenging the use of a six-month spenddown as violative of Title XIX. J.A. 8-24. The trial court certified a plaintiff class of AFDC-related medically needy applicants for or recipients of Medicaid subject to a six-month spenddown. Pet. A34-A35. The case was presented on summary judgment, both parties agreeing that there were no material facts in dispute. See Pet. A8.[20/] The trial court held that the six-month

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20/ The plaintiffs' Motion for Summary Judgment is set forth at J.A. 54. The Commissioner argued for judgment in his favor pursuant to Mass. R. Civ. P. 56(c) ("Summary judgment, when appropriate, may be rendered against the moving party.").

spenddown violated the "same methodology" requirement of TEFRA, because AFDC eligibility is determined on a monthly basis. Pet. A40-A42.[21]

The Supreme Judicial Court affirmed. After considerable attention to another issue,[22] that court addressed and invalidated the six-month spenddown in two paragraphs. Pet. A23-26. Essentially, the state's highest appellate court relied upon the analysis of Hogan v.

21/ The Amended Judgment, entered on May 24, 1984, declared the six-month spenddown provision of Mass. Gen. Laws ch. 118E, § 10, to be void pursuant to the Supremacy Clause and permanently enjoined the use of a spenddown period of longer than one month. Pet. A66 (¶ 4), A67 (¶ 6).

22/ Whether the failure to deduct payroll withholdings from earned income in calculating Medicaid eligibility violated state law -- the court found that it did not. Pet. A61, A10-A23; see J.A. 5-6.

Heckler, 597 F. Supp. 1106 (D. Mass. 1984), a federal trial court decision which has since been reversed by Hogan v. Heckler, 769 F.2d 886 (1st Cir. 1985). The court's substantive analysis was limited to the assertions that "the length of the spenddown period is part of the methodology for evaluating income eligibility," Pet. A24 (quoting 597 F. Supp. at 1110), and that the use of a six-month spenddown for medically needy eligibility is more restrictive than the one-month budget period used for the categorically needy, allegedly in violation of the intent of TEFRA as evidenced by a statement in subsequent legislative history. Pet. A25-26. The court "affirm[ed] that portion of the [Superior Court] judgment which determined that the department's use of a six-month budget period for

spend down purposes violated 42 U.S.C. § 1396a(a)(10)(C)(i)(III)." Pet. A26-27. The rescript so ordering entered on June 12, 1985. J.A. 5-6; Pet. A61-A62.

On August 12, 1985, Hogan v. Heckler, 769 F.2d 886 (1st Cir. 1985), and DeJesus v. Perales, 770 F.2d 316 (2d Cir. 1985), were decided -- both in direct conflict with the decision below. In order to bring these intervening authorities to the attention of the Supreme Judicial Court prior to seeking review in this Court, the Commissioner sought and received an extension of time in which to petition for certiorari, and filed a petition for rehearing, see J.A. 6, but the Supreme Judicial Court denied rehearing, without opinion, on September 26, 1985. J.A. 7; Pet. A63.

SUMMARY OF ARGUMENT

Massachusetts' use of a six-month spenddown for medically needy Medicaid eligibility is firmly grounded in a long-standing HHS regulation, which is entitled to deference. The "same methodology" requirement of 42 U.S.C. § 1396a(a)-(10)(C)(i)(III), inserted by the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA"), P.L. 97-248, § 137(b)(8), 96 Stat. 378, did not interdict this practice, which is employed by most states extending Medicaid coverage to medically needy; the legislative history shows clearly that in enacting this TEFRA amendment Congress did not intend to override, but instead expressly reaffirmed, the HHS regulation authorizing it.

A. The plain language of the TEFRA amendment does not encompass the spend-

down determination. The concept of offsetting medical expenses against income, the creation of 42 U.S.C. § 1396a(a)(17), is unique to the medically needy. Neither AFDC nor SSI has any "methodology" for a spenddown of medical expenses. The statute cannot mean that the spenddown determination, the flexible accounting for medical expenses against income, should be conducted by the "same methodology which would be employed" in determining the applicant's eligibility for AFDC or SSI, since those programs recognize no spenddown adjustment at all.

B. This statutory language was enacted as a "Technical Correction", with no hint in the legislative history that either its purpose or effect was to force 23 states and the District of Columbia to substantially expand the scope of

their medically needy programs by requiring a one-month spenddown.

Rather, Congress had something else very specifically in mind -- the rules for evaluating items of income -- when it enacted this language. The legislative history is clear that the phrase was inserted for the particular purpose of correcting a 1981 HHS regulatory amendment not involving the length of a spenddown. That 1981 HHS amendment, promulgated to implement the Omnibus Budget Reconcilation Act of 1981 ("OBRA"), P.L. 97-35, § 2171(a), 95 Stat. 807, had interpreted OBRA to give the states flexibility in evaluating certain types of income; the "same methodology" requirement was intended to reinstate the use of particular cash assistance program methodologies in that area. See H.R. Rep. No. 97-757, Part I, 97th Cong., 2d

Sess. 13 (1982). Congress expressly stated its intent to reinstate the prior regulatory scheme, and specifically reaffirmed certain HHS regulations which antedated OBRA, including the one which has always permitted a six-month spenddown period. Id.

In requiring a State to determine Medicaid eligibility in the same manner that was used prior to the recent series of amendments, the "same methodology" language clearly does not interdict the continued use of a six-month spenddown. In Massachusetts, this practice has been in effect since at least 1969. The federal policy permitting it was adopted by the Department of Health, Education and Welfare in 1966 and was incorporated in the first Medicaid regulations in 1969. That policy and practice have been con-

sistently maintained, both prior to and following OBRA. It is inconceivable that Congress intended to prohibit this widespread and important practice by adopting a "technical correction from OBRA" while expressly endorsing the longstanding HHS authorizing regulation.

C. The Secretary's consistent regulation, currently set forth at 42 C.F.R. § 435.831, originally adopted in 1966 pursuant to the express delegation of authority by Congress in 42 U.S.C. § 1396a(a)(17), is entitled to deference -- indeed, to legislative effect. By this regulation, and by the approval of numerous State plans, the Secretary has consistently authorized a six-month spenddown at all times before, during and after the recent series of congressional amendments, and Congress has never

questioned that interpretation. Since it is clearly within the scope of the Secretary's authority and is based upon a reasonable interpretation of Title XIX, it should be given controlling weight.

D. Nor is the Secretary's regulation authorizing six-month spenddowns invalid by virtue of the "comparability" requirement of 42 U.S.C. § 1396a(a)(17), which is irrelevant to the spenddown determination. Even if that provision extends to comparability between the categorically needy and the medically needy, which is very doubtful, the statute does not require such comparable treatment in all respects. Schweiker v. Hogan, 457 U.S. 569, 587 (1982). The flexible offset of medical expenses against income is one of the major distinguishing features between the categorically and the medically

needy. The fundamental difference in this aspect of financial eligibility forecloses any possibility that the "comparability" requirement is violated by a six-month spenddown.

ARGUMENT

MASSACHUSETTS' SIX-MONTH SPENDDOWN, WHICH WAS ADOPTED AND IS MAINTAINED PURSUANT TO A LONGSTANDING FEDERAL REGULATION, DOES NOT VIOLATE TITLE XIX AS AMENDED BY TEFRA.

A. The "Same Methodology" Language Has No Application to the Spenddown Determination, An Extra Step Unique to Medicaid.

This case involves the construction of 42 U.S.C. § 1396a(a)(10)(C)(i)(III), inserted by the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA"), P.L. 97-248, § 137(b)(8), 96 Stat. 378. That section applies to states, like

Massachusetts, which choose to extend Medicaid coverage to the medically needy. It requires the state, in determining "income . . . eligibility" of the medically needy under a "single standard," to use the "same methodology which would be employed," in the case of the plaintiff class, for determining their AFDC eligibility. In fact, the income of the plaintiff class in this case is calculated by Massachusetts according to the "same methodology" which would be employed for determining their AFDC eligibility, and then is measured against the "single standard" -- the medically needy income standard -- for determining their Medicaid income eligibility. See 42 C.F.R. § 435.831(b). In each case the applicant was found ineligible for Medicaid. Section 1396a(a)(10)(C)(i)(III)

requires no more. See DeJesus v. Perales, 770 F.2d 316, 326 (2d Cir. 1985).

Only thereafter does the state turn to the extra step of offsetting incurred medical expenses against excess income, a step provided by § 1396a(a)(17) (final clause). Neither the AFDC program nor the SSI program has any "methodology" for such a computation, since this offsetting concept is unknown to either program. In both cash assistance programs, net income is measured against a set income standard with no adjustment for medical expenses. In both programs the applicant or recipient's medical expenses are not taken into account in any way. It is, therefore, meaningless to suggest that the state, in taking into account medical expenses against excess income for the Medicaid program, must use the

"same methodology" as it uses for calculating AFDC or SSI eligibility. DeJesus v. Perales, 770 F.2d at 327.

The court below asserted that "the length of the spenddown period is part of the methodology for evaluating income eligibility." Pet. A24. The assertion that the word "methodology" is broad enough to encompass the length of the spenddown period, however, does not end the inquiry. In initiating the use of "methodology" in this context, HHS used it much more narrowly, referring to "such matters as deemed income, interest, court-ordered support payments, and infrequent and irregular income." 46 Fed. Reg. 47980 (Sept. 30, 1981) (quoted in context at p. 44, infra). Since Congress' use of the term in TEFRA was in direct response to that HHS initiative,

see pp. 45-46, infra, it is likely that Congress adopted the same restricted meaning. See Hogan v. Heckler, 769 F.2d 886, 901 (1st Cir. 1985).

Moreover, in concluding otherwise, the court below ignored or misapprehended the meaning and the objective of the complete statutory phrase -- "same methodology which would be employed under the appropriate State plan."[23/] Even accepting, arguendo, the abstract possibility that Congress could have used the word "methodology" in the statute more broadly than HHS had used it, consideration of the statutory phrase taken as a whole makes it clear that Congress did

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23/ In this case, the appropriate State plan is the AFDC plan. The language of the statute as it applies to the SSI-related medically needy is parallel. See p. 3, supra.

not in fact do so. The conclusion of the court below would make sense only if the qualifying statutory phrase ("which would be employed . . .") were directed to what length of spenddown period would be employed in the state's AFDC plan *if AFDC had a spenddown*. But this question, the answer to which is speculative in any event,[24/] is inapposite. Congress in plain language clearly was referring instead to a different situation, *viz.*, what methodologies would be employed *if the applicant had applied instead for AFDC*. The statute specifically refers to the methodologies "which would be employed under the appropriate State plan,"

24/ Although AFDC eligibility is determined on a monthly basis, the potential expansion inherent in the addition of a spenddown component might well lead to a different period for that aspect.

in this case the AFDC plan.[25/] The answer to that question indisputably is that no spenddown -- over any period -- would be recognized.

If Congress had intended to impose a requirement that the length of the medically needy spenddown period must be the same as the AFDC budget period, Congress could and surely would have said so. This is particularly true in light of the fact that such a requirement would have invalidated an important component of the State plans of 25 out of the 32 jurisdictions extending Medicaid coverage to the medically needy at that time.

25/ As will be noted below, the purpose of TEFRA's insertion of the "same methodology" requirement was precisely to reinstate actual AFDC (and SSI) methodologies for the evaluation of certain types of income.

"It will not be presumed that a federal statute was intended to supersede the power of the State unless there is a clear manifestation of intention to do so." New York Department of Social Services v. Dublino, 413 U.S. 405, 413 (1973). It is certainly not manifest that the phrase "same methodology which would be employed under the appropriate State plan" has any application to the spenddown determination, a determination unknown to any appropriate State plan.

Instead, the language which Congress used is so limited that it clearly cannot apply to the spenddown determination. Congress cannot possibly have intended the spenddown calculation to be conducted by the "same methodology which would be employed" for determining AFDC (or SSI) eligibility, since the offsetting of med-

ical expenses is an extra step, unique to the medically needy program.

B. The "Same Methodology" Language Was Intended To Do No More Than To Reinstate the Pre-OBRA Regulatory Scheme, Under Which Six-Month Spend-downs Abounded.

In ascertaining the intent of Congress in enacting this TEFRA amendment, it is essential to consider the legislative history. DeJesus v. Perales, 770 F.2d 316, 324 (2d Cir. 1985). See generally, Train v. Colorado Public Interest Research Group, 426 U.S. 1, 9-10 (1976); 2A N.J. Singer, Sutherland Statutory Construction § 48.01 (4th ed. 1984).

The "same methodology" language was added by the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA"), P.L. 97-248, § 137(b)(8), 96 Stat. 378. At

that time, out of 32 jurisdictions providing medically needy coverage, 25 used spenddown periods of greater than one month. R. 168; n. 12, supra. Federal law then (as now) required both SSI and AFDC eligibility to be determined on a monthly basis. See 42 U.S.C. §§ 602(a)-(13), 1382(c)(1) (1982 ed.). If the "same methodology" language was meant to require the length of a spenddown period to be the same, as the court below ruled, this TEFRA amendment represented a very substantial increase in the coverage of the medically needy programs in 23 states[26/] and the District of Colum-

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26/ Excluding one state, Illinois, since it is listed at R. 168 as also providing a one-month alternative. Although the respondents' theory would invalidate the six-month component, it would not appear to increase Illinois' coverage if a one-

(footnote continued)

bia.[27/] Under such circumstances, it might be anticipated that the amendment would receive significant attention in

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(footnote continued)

month option is already available. Of the other two states listed at R. 168 as having multiple spenddowns, neither of Washington's alternatives would survive, and Nebraska's one-month alternative is limited, see R. 161.

27/ The expansion of the Medicaid program from the imposition of a one-month spenddown would be dramatic. The state projected below that the increased payments in its AFDC-related medically needy program (which expended $47.8 million in fiscal year 1983) would be $19.6 million in the first year alone, R. 186, ¶ 12, with the potential for a substantially greater increase thereafter, see R. 148, ¶¶ 12-13. See also DeJesus v. Perales, 770 F.2d 316, 320 (2d Cir. 1985) ($78 million annually in New York for inpatient hospital care of AFDC-related medically needy alone). The imposition of a one-month spenddown would have a much greater financial impact with respect to the SSI-related medically needy groups, which have considerably greater medical costs since they are composed of elderly and disabled individuals.

Congress. However, quite the contrary was the case.

The notion that TEFRA was intended to result in an expansion of the Medicaid program flies in the face of the overall purpose of that Act, which was to reduce domestic spending in the face of large budget deficits.28/

This amendment in particular was part of a TEFRA section entitled: "Technical Corrections from Omnibus Budget Reconciliation Act of 1981." 96 Stat. 376. And no hint is given in the legislative history that either the purpose or the effect of the technical correction was to

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28/ See generally, Wing, "The Impact of Reagan-Era Politics on the Federal Medicaid Program," 33 Cath. U.L. Rev. 1 (1983). The "same methodology" amendment was part of Title I of TEFRA, which is entitled, "Provisions Relating to Savings in Health and Income Security Programs" (emphasis added). 96 Stat. 324.

force 23 states and the District of Columbia to enlarge the scope of their medically needy programs, or indeed to require any change whatsoever to those programs.

Rather, the legislative history is clear that Congress intended by this provision to do exactly what its title said: to make a technical correction -- more specifically, to correct a 1981 amendment to HHS regulations and to reinstate the earlier regulatory scheme.

Those 1981 HHS changes which TEFRA corrected came about in the following manner. Before the Omnibus Budget Reconciliation Act of 1981 ("OBRA"), P.L. 97-35, § 2171(a), 95 Stat. 807, states participating in the medically needy program were required by 42 U.S.C. § 1396a-(a)(10)(C)(i) to cover:

> all individuals who would, except for income and resources, be eligible for [AFDC or SSI] and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical and remedial care and services . . .

Under OBRA's amendment to § 1396a(a)(10)-(C)(i), if coverage was provided to any medically needy group, the state plan was instead required to:

> include a description of (I) the criteria for determining eligibility of individuals in the group for such medical assistance and (II) the amount, duration, and scope of medical assistance made available to individuals in the group . . .

The purpose of this statutory change was to provide States "with flexibility in establishing eligibility criteria and scope of services within the medically needy program to address the needs of different population groups more appro-

priately." H.R. Rep. No. 208, 97th Cong., 1st Sess. 971, reprinted in 1981 U.S. Code, Cong. & Admin. News 1333.

HHS responded to OBRA by promulgating regulations that provided states with greater flexibility in establishing programs for the medically needy. 46 Fed. Reg. 47976 et seq. (September 30, 1981). For example, the regulations provided for the adoption of medically needy programs applicable to less than all medically needy groups. See 46 Fed. Reg. 47978, amending 42 C.F.R. § 435.301(b).[29/] Unfortunately, how-

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29/ We are informed by HHS that the following states recently have adopted medically needy programs applicable to less than all medically needy groups, with spenddown periods as indicated: Georgia (six months); Iowa (two months); Oregon (six months); South Carolina (six months); and Texas (six months). Tennessee has reduced the scope of its medically needy program correspondingly (retaining its spenddown period of three months, see R. 168).

ever, HHS went beyond the intent of Congress and permitted new flexibility in the area of income and resource eligibility as well. For example, the new regulations permitted different income standards for different medically needy groups. See 46 Fed. Reg. 47979, amending 42 C.F.R. §§ 435.811-435.814.30/ HHS also promulgated several entirely new regulations, 42 C.F.R. §§ 435.850-435.852, which provided primarily and essentially that in determining eligibility of medically needy individuals, states would be permitted to use any methodology for the treatment of income and resources that was reasonable. See

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30/ The statute prior to OBRA had required "comparable standards," but the HHS regulations had required uniformity. TEFRA reinstated this requirement by the "single standard" language of § 1396a(a)-(10)(C)(i)(III). See p. 45-46, infra.

46 Fed. Reg. 47989. HHS explained these provisions as follows:

> States are no longer required to apply a uniform methodology for treating income and resources in such matters as deemed income, interest, court-ordered support payments, and infrequent and irregular income. Rather, the State plan must specify the methodology that will be used; and that methodology must be reasonable. (See 42 CFR 435.850-435.852 and 436.850-436.852, as added by this final rule.)

46 Fed. Reg. 47980 (Sept. 30, 1981).

The TEFRA amendment which added § 1396a(a)(10)(C)(i)(III) was passed in direct response to these HHS regulatory changes. In other words, the HHS changes were the "mischief" to which § 1396a(a)-(10)(C)(i)(III) was directed. As was explained by the House Energy and Commerce Committee in its Report on the amendment:

The 1981 Reconciliation Act gave the States certain specified flexibility in designing their medically needy programs. They are no longer required to cover all eligibility groups, e.g., aged, blind, or disabled persons and families with dependent children. They are no longer required to provide the same benefit package to each group they choose to cover. However, the 1981 Reconciliation Act made no changes in the applicable income and resource eligibility rules.

Unfortunately, the Department, in its interim final rule of September 30, 1981, 46 Fed. Reg. 47976, assumed that the conferees had intended to give the States extensive flexibility in this area as well. This is simply incorrect. When the Statement of Managers of the conference committee report spoke of providing the States "with flexibility in establishing eligibility criteria and scope of services within the medically needy program to address the needs of different population groups more appropriately," (H.R. Rep. 97-208, p. 971), it was referring to the service package and coverage group provisions, not inviting a wholesale rewriting of current income and resource standards

> and methodologies. This amendment makes clear that the Department had no authority to alter the rules that applied before September 30, 1981, with respect to medically needy income levels, medically needy resource standards, and the methodology for treating medically needy income and resources. The Committee bill reaffirms the financial requirements previously in effect for the medically needy (42 C.F.R. sec. 435.800-435.845).

H.R. Rep. No. 97-757, Part I, 97th Cong. 2d Sess. 13 (1982).

This dynamic generating the "same methodology" amendment clearly shows that the congressional intent in enacting that amendment was not to require a change in medically needy programs, but simply to restore the pre-OBRA regulatory scheme, insofar as it concerned financial eligibility. Hogan v. Heckler, 769 F.2d 886, 901 (1st Cir. 1985). The court below appeared to recognize this when address-

ing the other issue before it on the appeal. Quoting the recent congressional reconfirmation that TEFRA "amended the Medicaid statute to clarify that Congress did not intend to change the policies governing the [. . .] eligibility of the medically needy from those in effect before OBRA," H.R. Rep. No. 861, 98th Cong., 2d Sess., 1367 (1984), reprinted in 1984 U.S. Code Cong. & Admin. News 2055, the court concluded: "Our examination of this legislative history indicates that 42 U.S.C. § 1396a(a)(10)(C)-(i)(III) requires a State to determine [Medicaid] eligibility in the same manner that was used prior to the recent series of amendments." Pet. A17-A18.

This understanding, which is entirely correct, leads inexorably to the conclusion that the continued use of a six-month spenddown was not interdicted by

TEFRA. As previously noted, the pre-OBRA HHS regulations authorized, and most participating states pursuant to that authorization then used, six-month spend-downs in their determination of medically needy eligibility.[31/]

31/ However, when the court below turned to this issue it ignored its earlier conclusion. Instead, it misconstrued H.R. Rep. No. 98-861 by citing it for the assertion that Congress intended in TEFRA to prevent more restrictive treatment of the medically needy than of the categorically needy. Pet. A26. The Report (which concerns the subsequent partial moratorium, 98 Stat. 1112, P.L. 98-369, § 2373(c), upon the Secretary's enforcement of the TEFRA amendment) evidences Congressional concern that the Secretary may have overreacted to the TEFRA amendment by prohibiting certain less restrictive practices which had been permitted prior to OBRA, contrary to the Congressional intent in TEFRA to reinstate the practices in effect prior to OBRA. The statement (H.R. Rep. No. 98-861 at 1368) that States "are still foreclosed from being more restrictive than the relevant cash assistance programs" simply points out what is clear on the face of the mor-

(footnote continued)

Moreover, the last sentence of the TEFRA Report quoted at pp. 45-46 above is of particular importance for another reason: it specifically "affirm[ed] the

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(footnote continued)

atorium statute, that the moratorium does not apply with respect to practices viewed by the Secretary as being more restrictive, presumably because Congress had no cause for concern (it expressed none) about the Secretary's enforcement in that area. In any event, neither the plain language of TEFRA nor its legislative history supports a "no more restrictive" interpretation; nor does H.R. Rep. No. 98-861 taken as a whole. Finally, even if it were proper to read a "no more restrictive" gloss onto the TEFRA amendment, it begs the question to assert that a six-month spenddown is more restrictive. HHS, which prior to OBRA had required states to use the same rules for determining income eligibility for the medically needy as were used in determining categorically needy eligibility, see 46 Fed. Reg. 47980 (quoted at p. 44, supra), never took the position that the length of the medically needy spenddown was thereby required to be the same as the budget period for the applicable categorical program. See 42 C.F.R. § 435.831.

financial requirements" previously contained in 42 C.F.R. §§ 435.800 - 435.845. This included the Secretary's regulation authorizing the practice challenged in this case of employing a prospective six-month period for the medically needy spenddown determination. In light of the fact that Congress the year before had adopted retrospective, monthly budgeting for both AFDC and SSI eligibility determinations, see OBRA, P.L. 97-35, §§ 2315 and 2341, 95 Stat. 855 and 865 (1981), "[i]t is hard to imagine a clearer indication that Congress did not intend to equate the length of the spenddown period with the length of the budget period used to determine income." Hogan v. Heckler, 769 F.2d 886, 901 (1st Cir. 1985).

Clearly, Congress did not contemplate an expansion of Medicaid coverage when it

enacted this "technical amendment". Its intention was simply to correct an HHS misinterpretation of the OBRA amendments. In so doing, Congress graphically demonstrated its awareness of the HHS regulatory scheme and its readiness to correct HHS when necessary or appropriate. That it did not correct, but instead affirmed, the six-month spenddown regulation makes it clear beyond peradventure that TEFRA was not intended to invalidate the use of a six-month spenddown.

C. The Secretary's Consistent Regulation Authorizing Six-Month Spenddowns Governs this Case.

Title XIX of the Social Security Act is a statute of "unparalleled complexity," DeJesus v. Perales, 770 F.2d 316, 321 (2d Cir. 1985), "among the most in-

tricate ever drafted by Congress." Schweiker v. Gray Panthers, 453 U.S. 34, 43 (1981). "Perhaps appreciating the complexity of what it had wrought, Congress conferred on the Secretary exceptionally broad authority to prescribe standards for applying certain sections of the Act." Id.

Such authority with specific reference to medically needy spenddowns was conferred by Congress precisely in the final clause of 42 U.S.C. § 1396a(a)(17), which delineates the spenddown concept: the state plan must -- "provide for flexibility in the application of such standards [for determining eligibility for and the extent of medical assistance under the plan] with respect to income by taking into account, except to the extent prescribed by the Secretary, the

costs . . . incurred for medical care" (emphasis added).[32/]

Pursuant to Congress' authorization, the Secretary of Health and Human Services and before him the Secretary of Health, Education and Welfare has consistently, since the inception of the Medicaid program, sanctioned the use of a spenddown period of up to six months. HEW Handbook of Public Assistance Administration, Supplement D, Section D-4220(A)(4) (June 17, 1966) (reproduced in the appendix hereto).[33/] This

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32/ See also 42 U.S.C. § 1302 (granting to the Secretary the authority to "make and publish such rules and regulations, not inconsistent with" the Act "as may be necessary [for its] efficient administration.").

33/ See also id., § D-4240(A)(3): "Since the income level for maintenance will usually be expressed as 'annual income,' for administrative purposes the

(footnote continued)

authorization was retained in the first set of HEW Medicaid regulations in 1969, 34 Fed. Reg. 1321 (Jan. 28, 1969), codified at 45 C.F.R. § 248.21(a)(4) (1969), and is now set forth in 42 C.F.R. § 435.831 (1985). These regulations "plainly permit" a six-month spenddown. DeJesus v. Perales, 770 F.2d 316, 322 (2d Cir. 1985); Hogan v. Heckler, 769 F.2d at 889, 896.[34/]

(footnote continued)

individual's or family's income will have to be measured on a monthly basis in relation to the medical needs and not to exceed six months ahead, beginning with the month in which the medical service was rendered. Six months is the maximum time period in which income can be considered available for meeting medical care costs."

34/ The six-month provision for computation of income of the medically needy for spenddown purposes has been maintained throughout the entire history of the regulation. See 36 Fed. Reg. 3860

(footnote continued)

Pursuant in turn to this federal regulation, twenty-eight states[35/] and the District of Columbia have chosen to participate, and for twenty years states have participated, in the medically needy program using a spenddown period in excess of one month (in most, of six months). In each case, the Secretary has approved the State plan so providing. Cf. R. 161 (re HHS review of State plans).

(footnote continued)

(Feb. 27, 1971), codified at 45 C.F.R. § 248.21(3)(iv); 39 Fed. Reg. 9517 (March 11, 1974), deleting the three-month provision and transferring the regulation to 45 C.F.R. § 248.3(c)(4); 42 Fed. Reg. 52827 (Sept. 30, 1977), redesignating 45 C.F.R. Part 248 as Part 448; 43 Fed. Reg. 45176, 45177 (Sept. 29, 1978), transferring 45 C.F.R. § 448.3(c)(4) to 42 C.F.R. § 435.831 insofar as it concerned income eligibility; 45 Fed. Reg. 24886 (Apr. 11, 1980), amending 42 C.F.R. § 435.831.

35/ Including five new states subsequent to TEFRA, see n. 29, supra, but excluding Illinois, see n. 26, supra.

The Secretary's consistent interpretation over the twenty-year life of Medicaid is entitled, at a minimum, to "substantial deference" by reviewing courts. Connecticut Department of Income Maintenance v. Heckler, ___ U.S. ___, 105 S. Ct. 2210, 2215 (1985).[36/] Under this familiar standard, "the agency's construction need not be the only reasonable one in order to gain judicial approval." Id. The Secretary's interpretation of Title XIX as permitting a six-month spenddown for medically needy eligibility is clearly reasonable.

36/ See also, e.g., United States v. Riverside Bayview Homes, Inc., ___ U.S. ___, 106 S. Ct. 455, 461 (1985); Chevron, USA, Inc. v. Natural Resources Defense Council, Inc., 467 U.S. ___, 104 S.Ct. 2778, 2782-83 (1984); Norwegian Nitrogen Co. v. United States, 288 U.S. 294, 315 (1933) (opinion of Cardozo, J.).

Moreover, when made pursuant to an explicit delegation of substantive authority, as here, the Secretary's interpretation is entitled to legislative effect. Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. ___, 104 S. Ct. 2778, 2782 (1984); Herweg v. Ray, 455 U.S. 265, 274-75 (1982); Schweiker v. Gray Panthers, 453 U.S. 34, 43-44 (1981); Batterton v. Francis, 432 U.S. 416, 425-26 (1977). Under that standard, the regulation must be given controlling weight unless it is either arbitrary and capricious or beyond the Secretary's statutory authority, Gray Panthers, supra, 453 U.S. at 44, which it clearly is not.

The court below, in striking violation of these principles, acknowledged the argument, Pet. A23-A24, and then pro-

ceeded to totally ignore the Secretary's regulation. Pet. A24-26. By contrast, the First and Second Circuits recognized these important principles governing judicial construction of federal statutes, and applied them accurately to the present context by according deference to the Secretary's regulation. DeJesus v. Perales, 770 F.2d at 327; Hogan v. Heckler, 769 F.2d at 888, 892 and n. 12, 896-97, 902.[37/]

As in Connecticut Department of Income Maintenance, supra, in this case "Congress has never indicated dissatisfaction with the Secretary's undeviating

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37/ See also Williams v. St. Clair, 610 F.2d 1244, 1248-49 (5th Cir. 1980) (deferring to Secretary's spenddown regulations in a § 209(b) context, even though 42 U.S.C. § 1396a(f) lacks the express delegation of spenddown authority contained in § 1396a(a)(17)).

construction." 105 S. Ct. at 2215. In enacting TEFRA, Congress addressed itself to the very subpart in which the Secretary's authorization at issue is found, and corrected other regulations, but "reaffirmed" this one. This is further evidence that the Secretary has not exceeded his authority in promulgating the regulation and that it is neither arbitrary and capricious nor manifestly contrary to the statute but instead is a reasonable interpretation of Title XIX. It follows that the regulation entitled to controlling weight in this case and that Massachusetts' use of a six-month spend-down under its authority is valid.

D. The Six-Month Spenddown Was Never in Conflict With, But Was in Fact Authorized by the Secretary Pursuant To, 42 U.S.C. § 1396a(a)(17).

Nor were the Secretary's regulation and Massachusetts' practice contrary to the "comparability" requirement of 42 U.S.C. § 1396a(a)(17) even before TEFRA, as the complaint alleges. Although the court below did not address the point, it may be raised in support of the judgment. The Second Circuit saw "little force" to the contention in DeJesus v. Perales, 770 F.2d 316, 323 (2d Cir. 1985), and it was rejected after a comprehensive inquiry in Hogan v. Heckler, 769 F.2d 886, 891 et seq. (1st Cir. 1985).38/

38/ The plaintiffs in DeJesus v. Perales, 770 F.2d at 323, n. 9 and in Hogan v. Heckler, 769 F.2d at 893-94,

(footnote continued)

In fact, the income standard com-

(footnote continued)

recognized that the Secretary's regulation was valid for 15 years (1966 to 1981), but argued that OBRA's adoption of one-month budget periods for AFDC and SSI invalidated it. In fact, however, prior to OBRA, SSI was calculated on a quarterly basis in all states, see P.L. 92-603, § 301, 86 Stat. 1466 (thereby mandating a three-month spenddown for SSI-related medically needy applicants under respondents' theory), and "throughout the period during which the Secretary's regulation permitting a six-month spend-down has been in force, eligibility for AFDC has been determined by calculating income on a monthly basis." DeJesus v. Perales, 770 F.2d at 323 n. 9; see 42 U.S.C. §§ 602(a)(8), (28) (1976 ed.). The purpose of the OBRA changes was to reduce overpayments by requiring retrospective budgeting and monthly reporting, S. Rep. No. 139, 97th Cong., 1st Sess. 516-17 (1981), which was intended to contract, not expand, the social welfare budget by millions of dollars annually, and the legislative history belies any congressional intention to override the widespread use of six-month spenddowns. "Had Congress meant to invalidate all these state programs plus the Secretary's longstanding regulation, it hardly would have done so through the indirect method

(footnote continued)

parability provision of § 1396a(a)(17) is irrelevant to the spenddown calculation. Section 1396a(a)(17) requires that the State use "reasonable standards" for determining income and resource eligibility and the extent of medical assistance. It is those standards "which shall be comparable for all groups." The same section provides for flexibility in the application of such standards with respect to income by taking into account, "except to the extent prescribed by the Secretary," costs incurred for medical

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(footnote continued)

of an amendment to the SSI and AFDC requirements alone, without any reference whatever to the medically needy." Hogan v. Heckler, 769 F.2d 886, 896 (1st Cir. 1985). Nor would it have reaffirmed the regulation the following year. See pp. 46, 49-50, supra.

and remedial care.[39] That spenddown calculation is unique to the medically needy who, unlike the categorically needy, have income in excess of the standard.[40]

39/ It is noteworthy that when describing the operation of the spenddown concept in 1965, Congress used annual figures. H.R. Rep. No. 213, 89th Cong., 1st Sess. 68 (1965); Cong. Rec., 89th Cong., 1st Sess. S15876 (July 8, 1965) (remarks of Senator McNamara, the bill's cosponsor in the Senate).

40/ Moreover, it is the petitioner's position that the general comparability provision of § 1396a(a)(17) does not extend to comparability between the categorically and the medically needy. The legislative history of the Social Security Amendments of 1965, which inserted this requirement (79 Stat. at 346) evidences instead a concern for comparability among the various categorical groups of needy people. S. Rep. No. 404, 89th Cong., 1st Sess. 77, 78-79 (1965), reprinted in 1965 U.S. Code Cong. & Admin News 1943, 2017, 2018-19; H.R. Rep. No. 213, 89th Cong., 1st Sess. 66-67 (1965). See R. Stevens & R. Stevens, Welfare Medicine in America (1974) 63. This

(footnote continued)

The Secretary, whose regulations in many other respects have adopted quite a broad reading of comparability, has consistently taken the position that the length of the spenddown used for medically needy eligibility need not be the same as the budget period for the applicable categorical program. And this Court also has recently cautioned that the comparability provisions of §§ 1396a(a)(10) and (17), whatever their scope, "did not require that the medically needy be treated comparably to the categorically needy in all respects."

(footnote continued)

Court recognized as much in Schweiker v. Hogan, 457 U.S. 569, 574, n. 6 (1982). However, some courts have adopted a broader interpretation, see id. at 587, n. 28. As in Schweiker v. Hogan, this broad issue need not be reached.

Schweiker v. Hogan, 457 U.S. at 587. The present context involves one of the salient respects in which the medically needy are required to be treated differently from the categorically needy -- by virtue of § 1396a(a)(17) itself. Those individuals receiving cash assistance under AFDC or SSI are eligible for Medicaid automatically, and the spenddown provision of § 1396a(a)(17) has no application to them. See Fullington v. Shea, 320 F. Supp. 500 (D. Colo. 1970), aff'd summarily, 404 U.S. 963 (1971). The plaintiff class is eligible for Medicaid only by virtue of a flexible accounting for medical costs which has no counterpart in the underlying categorical programs. In choosing to extend Medicaid coverage to medically needy groups through offsetting their excess income

with medical expense, Massachusetts is engaging in a procedure which is unique to its medically needy applicants. Judge Friendly expressed the point aptly and succinctly:

> [S]ince the very purpose of § 1396a(a)(17) is to regulate the standards under which persons having incomes higher than allowed in the cash assistance programs may still qualify for Medicaid, it cannot be read to require that the standards must be the same as those in the cash assistance programs in all respects. The direction is that the standards shall be "comparable," not identical, for all groups. Comparison invites an examination of differences as well as resemblances. . . . Read together, the requirements of "comparability" and "flexibility" imposed by § 1396a(a)(17) simply do not mandate the rigidly identical treatment of categorically and medically needy Medicaid recipients for which plaintiff contends.

DeJesus v. Perales, 770 F.2d 316, at 324 (2d Cir. 1985). In short, there was

never any serious doubt under § 1396a(a)-(17) that the six-month spenddown, which is sanctioned by HHS under the authority of § 1396a(a)(17) itself, was valid.[41/]

41/ In addition, one specific concern of the 90th Congress, which amended Title XIX to place a limit upon the level of the income standard which a state could adopt subject to federal financial participation, P.L. 90-248, § 220(a), adding 42 U.S.C. § 1396b(f), was that high medically needy income standards would lead individuals to forego insurance. Schweiker v. Hogan, 457 U.S. at 577-78 (quoting H.R. Rep. No. 544, 90th Cong., 1st Sess. 118 (1967)). Granting the remedy sought by the respondents here would create a disincentive for employers to offer, and employees to seek, health insurance coverage. A likely result of a one-month spenddown policy would be a form of financial planning whereby routine medical treatments would be scheduled in the same month so as to reduce one's own financial liability, rather than scheduling such appointments over a more manageable period. It is entirely possible, if not predictable, that individuals aware of the possibility of a one-month spenddown would become self-insurers, bypassing available private insurance with the knowledge that Medicaid coverage would be available for high-expense months.

CONCLUSION

For the reasons stated above, the decision below should be reversed.

Respectfully submitted,

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January, 1986

APPENDIX

42 U.S.C. § 1396a(a)(10) (1982 ed.)

Section 1396a(a)(10) of Title 42 of the United States Code, as amended by the Tax Equity and Fiscal Responsibility Act of 1982, P.L. 97-248, provides in pertinent part as follows:

42 U.S.C. § 1396a(a). A State plan for medical assistance must--

* * *

(10) provide--

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5) and (17) of section 1396d(a) of this title, to--

(i) all individuals receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI of this chapter,

or part A or part E of subchapter IV of this chapter (including pregnant women deemed by the State to be receiving such aid as authorized in section 606(g) of this title and individuals considered by the State to be receiving such aid as authorized under section 614(g) of this title), or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter; and

(ii) at the option of the State, to any group or groups of individuals described in section 1396d(a) of this title (or, in the case of individuals described in section 1396d(a)(i) of this title, to any reasonable categories of such individuals) who are not individuals described in clause (i) of this subparagraph but--

(I) who meet the income and resources requirements of the appropriate State plan described in clause (i) or the supplemental security income program (as the case may be),

(II) who would meet the income and resources requirements of the appropriate State plan described in clause (i) if their work-related child care costs were paid from their earnings rather than by a State agency as a service expenditure,

(III) who would be eligible to receive aid under the appropriate State plan described in clause (i) if coverage under such plan was as broad as allowed under Federal law,

(IV) with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, aid or assistance under the appropriate State plan described in clause (i), supplemental security income benefits under subchapter XVI of this chapter, or a State supplementary payment;

(V) who are in a medical institution, who meet the resource requirements of the appropriate State plan described in clause (i) or the supplemental security income program, and whose income does not exceed a separate income standard established by the State which is consistent with the limit

established under section 1396b(f)(4)(C) of this title, or

(VI) who would be eligible under the State plan under this title if they were in a medical institution, with respect to whom there has been a determination that but for the provision of home or community-based services described in section 1396n(c) of this title they would require the level of care provided in a hospital, skilled nursing facility or intermediate care facility the cost of which could be reimbursed under the State plan, and who will receive home or community-based services pursuant to a waiver granted by the Secretary under section 1396n(c) of this title;

(B) that the medical assistance made available to any individual described in subparagraph (A)--

(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A);

(C) that if medical assistance is included for any group of individuals described in section 1396d(a) of this title who are not described in subparagraph (A), then--

(i) the plan must include a description of (I) the criteria for determining eligibility of individuals in the group for such medical

assistance, (II) the amount, duration, and scope of medical assistance made available to individuals in the group, and (III) the single standard to be employed in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligibility, which shall be the same methodology which would be employed under the supplemental security income program in the case of groups consisting of aged, blind, or disabled individuals in a State in which such program is in effect, and which shall be the same methodology which would be employed under the appropriate State plan (described in subparagraph (A)(i)) to which such group is most closely categorically related in the case of other groups;

(ii) the plan must make available medical assistance--

(I) to individuals under the age of 18 who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A)(i), and

(II) to pregnant women, during the course of their pregnancy, who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A);

* * *

42 U.S.C. § 1396a(a)(17) (1982 ed.)

42 U.S.C. § 1396a(a). A State plan for medical assistance must--

* * *

(17) include reasonable standards (which shall be comparable for all groups and may in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter, based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent

of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or to have paid with respect to him supplemental security income benefits under subchapter XVI of this chapter) as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits, (C) provide for reasonable evalua-

tion of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1382c of this title (with respect to States which are not eligible to participate in such program); and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance prem-

iums or otherwise) incurred for medical care or for any other type of remedial care recognized under State law;

Handbook of Public

Assistance Administration

Supplement D

Medical Assistance Programs

D-4200 Financial Eligibiity 6/17/66

D-4220. Requirements for State Plan

A. A State plan for medical assistance, if it includes the medically needy (see D-4000), must:

1. Provide levels of income and resources for maintenance, in total dollar amounts, as a basis for establishing financial eligibility for medical assistance, in accordance with the following:

a. Such income levels must be comparable as among individuals and families of varying sizes.

* * *

2. Provide that there will be a flexible measurement of available income which will be applied in the following order of priority:

* * *

3. Provide that all income and resources (after all State policies governing that disregard, or setting aside for future needs, of income and resources in the States approved plans under titles I, IV, X, XIV, and XVI, have been applied) will be considered in establishing eligibility, and in the flexible application of income to medical costs not in the State plan, and payment toward the medical assistance costs.

4. Provide that only such income and resources as are actually available will be considered; that income and resources will be reasonably evaluated; and that only such income and resources will be considered as will be "in hand" within a period, preferably of not more than three months, but not in excess of six months, ahead, including the month in which medical services were rendered for which payment would be made under the plan.

5. Provide that financial responsibility of any individual for any applicant or recipient of medical assistance will be limited to the responsibility of spouse for spouse and of parents

for children under age 21, or blind, or permanently and totally disabled; and specify the extent to which the financial responsibility of any such relatives is taken into account.

42 C.F.R. § 435.831 (1985)

§ 435.831 Income eligibility.

The agency must determine income eligibility of medically needy individuals in accordance with this section. The agency must use a prospective period of not more than 6 months to compute income.

(a) Determining countable income. The agency must deduct the following amounts from income to determine the individual's countable income.

(1) For individuals under age 21 and caretaker relatives, the agency must deduct amounts that would be deducted in determining eligibility under the State's AFDC plan.

(2) For aged, blind, or disabled individuals in States covering all SSI recipients, the agency must deduct

amounts that would be deducted in determining eligibility under SSI. However, the agency must also deduct the highest amounts from income that would be deducted in determining eligibility for optional State supplements if these supplements are paid to all individuals who are receiving SSI or would be eligible for SSI except for their income.

(3) For aged, blind, or disabled individuals in States using income requirements more restrictive than SSI, the agency must deduct amounts that are no more restrictive than those used under the Medicaid plan on January 1, 1972 and no more liberal than those deducted in determining eligibility under SSI or an optional State supplement. However, the amounts must be at least the same as those that would be deducted in determin-

ing eligibility, under § 435.121, of the categorically needy.

(b) Eligibility based on countable income. If countable income determined under paragraph (a) of this section is equal to or less than the applicable income standard under § 435.814, the individual or family is eligible for Medicaid.

(c) Deduction of incurred medical expenses. (1) If countable income exceeds the income standard, the agency must deduct from income, in the following order, incurred medical expenses that are not subject to payment by a third party:

(i) Medicare and other health insurance premiums, deductibles, or coinsurance charges, incurred by the individual or family or financially responsible relatives, including enrollment fees,

copayments, or deductibles imposed under § 447.51 or §447.53 of this subchapter.

(ii) Expenses incurred by the individual or family or financially responsible relatives for necessary medical and remedial services that are recognized under State law but not included in the plan.

(iii) Expenses incurred by the individual or family or by financially responsible relatives for necessary medical and remedial services that are included in the plan.

(2) The agency may set reasonable limits on the amounts of incurred medical expenses to be deducted from income under paragraphs (c)(1)(i) and (ii) of this section.

(d) Eligibility based on incurred medical expenses. Once deduction of incurred medical expenses reduces income

to the income standard, the individual is eligible for Medicaid.

Massachusetts General Laws

Chapter 118E, § 10 (1984 ed.)

The fourth unnumbered paragraph of section 10 of chapter 118E of the Massachusetts General Laws, as inserted by Mass. Stat. 1969, c. 800, § 1, provides as follows:

§ 10.

* * *

In any case where the monthly income of a recipient or beneficiary is in excess of the exemptions allowed, the recipient or beneficiary shall be liable to pay to the provider of medical care or service an amount which shall be equal to the excess income for a period of six consecutive months, which includes the period when such service was provided.

* * *

106 Code Massachusetts Regulations

§ 506.400: MA Income Standards

The MA Income Standards are the standards of need established by the Department and used for the determination of financial eligibility.

Eligibility shall be established for an otherwise eligible individual whose Net MA Income is equal to or less than the applicable MA Standard. If Net MA Income is greater than the MA Income Standard, eligibility may be established on the basis of the spenddown provisions.

§ 506.510: The Spend-Down Period

The spend-down period is a six (6) month prospective period which starts on the first day of the month of service of the earliest bill used to meet the spend-down amount. This date shall not be earlier than three (3) months prior to

the month of application and shall not extend more than six months from the first day of application.

§ 506.520: Calculating the Spend-Down Liability

The spend-down liability is the amount of excess income that the applicant or recipient is considered to have available to meet medical expenses during the spend-down period.

The amount by which the Net MA Income exceeds the MA Income Standards is the excess monthly income. The spend-down liability is determined by multiplying the excess monthly income by six.

§ 506.570: Conclusion of the Spend-Down Process

When bills submitted are equal to or greater than the spend-down liability

and all other eligibility requirements continue to be met, the applicant shall be notified that he is eligible. The recipient is eligible for payment of all covered medical expenses incurred during that spend-down period, other than those submmitted to meet the spend-down liability, as long as all other eligibility requirements continue to be met during the balance of the spend-down period.

Supreme Court, U.S.
FILED
FEB 28 1986
JOSEPH F. SPANIOL, JR.
CLERK

No. 85-632

IN THE

Supreme Court of the United States

OCTOBER TERM, 1985

CHARLES ATKINS, Commissioner of the Massachusetts Department of Public Welfare,
Petitioner,

v.

SANTOS RIVERA, MADELINE MCKENNA, and all others similarly situated,
Respondents.

On Writ Of Certiorari To The Supreme Judicial Court Of Massachusetts

---

BRIEF FOR RESPONDENT McKENNA

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QUESTIONS PRESENTED

Whether a State violates the Social Security Act requirement that medical assistance ("Medicaid") income eligibility must be determined using the same methodology as it uses in determining income eligibility for Aid to Families with Dependent Children ("AFDC"), when the State counts six months' income in determining Medicaid eligibility but counts only one month's income in determining AFDC eligibility?

Whether the policy of the Department of Health and Human Services ("HHS") allowing States to determine Medicaid income eligibility for a period of up to six months is entitled to any judicial deference, when Congress had previously delegated legislative authority to the Secretary of HHS to prescribe standards for such determinations of income eligibility, but has since withdrawn that delegation?

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STATEMENT OF THE CASE

Respondents, mothers of minor children, applied for medical assistance ("Medicaid") for the medically needy.[1] Their applications were denied, and their administrative hearings challenging those denials were unsuccessful. In those administrative "fair hearings" the referee held that their "net income and six month surplus" were correctly computed [Pet. A52, A59].

Respondent Rivera commenced this class action [J.A. 11-12],[2] and respondent McKenna intervened as a plaintiff [J.A. 32]. Both complaints alleged that the Massachusetts

> policy and practice of using a six month period for calculating the income of AFDC-related medically needy applicants for and recipients of Medicaid violates 42 U.S.C. § 1396a(a)(10)(C)(i)(III) insofar as it employs a different budgeting methodology to determine their Medicaid eligibility than is used to determine eligibility for the AFDC program. [J.A. 21, 43.]

---

[1] States are generally required to provide Medicaid for recipients of federally financed cash public assistance benefits, *i.e.*, children and caretaker relatives receiving Aid to Families with Dependent Children ("AFDC") benefits [42 U.S.C. §§ 601 *et seq.*] and the aged, blind and disabled receiving Supplemental Security Income ("SSI") benefits [42 U.S.C. §§ 1381 *et seq.*]. These are the "categorically needy." 42 C.F.R. § 435.4. Respondents are "medically needy," *i.e.* persons who would be categorically needy except for excess income or resources. *Id.* Because respondents were categorically eligible for AFDC they and the class [Pet. A65] are "AFDC-related." As the Petition (p. 16) concedes, the analysis in this case applies with equal force to the "SSI-related" group of aged, blind and disabled medically needy Medicaid applicants. Whether the Massachusetts policy of calculating eligibility on a six-month basis for the SSI-related violates the Social Security Act is the issue in *Hogan* v. *Bowen*, *petition for certiorari docketed* No. 85-6386 (U.S. Feb. 14, 1986).

[2] References "J.A." are to the Joint Appendix.

Ms. Rivera was employed full time and had gross monthly income of only $610.30. After applying a standard deduction of $75.00 for all her taxes and other work expenses, Massachusetts computed her net monthly income as $535.30. Since that was $100.30 more than the monthly Medicaid income allowance for a family of three, Ms. Rivera and her two children (then aged 11 and 13 [R.57][3] were only eligible for Medicaid if, during the six-month eligibility period, she became liable for $601.80 of medical bills—six times their monthly excess income [Pet. A50-A52].[4] The Riveras were thus determined ineligible despite incurring $314.00 of unpaid medical bills, more than one-half their gross monthly income, in one month alone [R. 73-74].

Ms. McKenna was also a working mother with a 13-year-old child [R. 121]. She had net monthly income of $531.66 (after the standard $75.00 tax and work expense deduction) which was $106.66 more than the Medicaid income allowance of $425.00 monthly for a family of two [Pet. A57]. Accordingly Massachusetts determined that the McKennas would only be eligible for Medicaid once they incurred $639.96 of medical bills (6 x $106.66) for the six-month eligibility period [*Id.*].[5]

---

[3] References "R" are to the Record Appendix below.

[4] The medically needy are eligible for Medicaid if they incur medical expenses which exceed the difference between their net income (gross income less $75.00 for work expenses for respondents under Massachusetts law) and the Medicaid eligibility level. In Medicaid jargon this is their "spend-down." That term does not appear in the Social Security Act or federal Medicaid regulations; it is administrative shorthand for another of many deductions from income used in determining Medicaid income eligibility.

[5] The State's brief (p. 16, n.18) suggests for the first time that the McKennas' eligibility was not actually affected by the six-month

The trial court granted respondents' summary judgment motion [J.A. 54], holding that the State's policy of determining Medicaid applicants' income on a semi-annual basis while determining AFDC eligibility by examining income on a monthly basis violated the requirement[6] that the State determine Medicaid income eligibility for the AFDC-related medically needy using the same methodology that it uses to determine AFDC income eligibility for the categorically needy [Pet. A39-A42]. The trial court rejected as "totally without merit" the contention the State renews in this Court that its six-month computation was not a determination of income eligibility [Pet. A41].

The trial court likewise rejected another argument the State raises in this Court, that its six-month income eligibility rule is authorized by 42 C.F.R. § 435.831. The trial court held that 42 U.S.C. § 1396a(a)(10)(C)(i)(III), enacted after the promulgation of 42 C.F.R. § 435.831, controlled over the regulation [Pet. A43]. Accordingly it entered judgment (as amended in respects not relevant here) certifying a class of AFDC-related medically needy

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income determination. This is incorrect. Since it was not raised below, the record is not developed on this point, but it is a fact that because she fell behind on the $70.00 monthly payments for her son's dental care Ms. McKenna paid $190.00 in January, 1984, and $140.00 in November, 1984. Federal policy permits an applicant to use unpaid back bills to meet a given month's obligation, so the McKennas would have been Medicaid eligible (using one-month income eligibility) in, *e.g.* November, 1984, since they presented unpaid $70.00 dental bills for October and November. *See* 48 Fed.Reg. 39960, 39961 (1983). In any event the case was certified as a class action and no question has been raised as to the adverse effect the State's policy had on the other class representative, respondent Rivera.

[6] Under 42 U.S.C. § 1396a(a)(10)(C)(i)(III).

Medicaid applicants or recipients subjected to the six-month spend-down requirement [Pet. A65], declaring that the six-month requirement violates 42 U.S.C. § 1396a(a)(10)(C)(i)(III) [Pet. A66], enjoining use of a spend-down requirement of more than one month [Pet. A67], and requiring eligibility recomputations on a monthly basis [Pet. A68-A69].

On appeal by the Commissioner of Public Welfare the Massachusetts Supreme Judicial Court affirmed on the issue presented in this Court [Pet. A23-27]. It held that the issue was not, as the State argued and still argues in this Court, that AFDC has no spend-down, but rather that whatever budget period is used to determine income eligibility for AFDC must be used for Medicaid eligibility as well as [Pet. A25]. It thus agreed with the trial court that the State's use of a six-month income budgeting period violated 42 U.S.C. § 1396a(a)(10)(C)(i)(III) [Pet. A26-A27] and entered judgment accordingly [Pet. A61-A62].

On the petition of the Commissioner of the Massachusetts Department of Public Welfare, this Court granted a writ of certiorari to review the judgment of the Massachusetts Supreme Judicial Court that the use of a six-month income budget period violates 42 U.S.C. § 1396a(a)(10)(C)(i)(III).[7] ___ U.S. ___, 106 S.Ct. 566 (1985).

---

[7] While petitioner and the *amici* supporting petitioner have also briefed whether the State's policy violates 42 U.S.C. § 1396a(a)(17), that issue is premature and respondent does not rely on that section in defense of the judgment. That issue, if it ever needs to be addressed, should be left to another day. The courts below did not rely on § 1396a(a)(17), and, in respondent's view, § 1396a(a)(10)(C)(i)(III) is determinative of this case. Hence respondent declines the invitation to join issue here on whether the State's policy also violates § 1396a(a)(17).

SUMMARY OF ARGUMENT

1. The statute in question, 42 U.S.C. § 1396a(a)(10)-(C)(i)(III), concerns the State's policy for "determining income . . . eligibility," and requires that it be determined using the same methodology as the State uses under AFDC. Income eligibility for AFDC (and for SSI) is determined on a monthly basis, and the Medicaid statute incorporates that same requirement by requiring the use of the same methodology for determining income eligibility as is used by AFDC [P. 8].

It is impossible to determine "income" without regard to a period of time. Time is an essential element in the measure of income. The statute should be construed in light of the ordinary meaning of "income" as involving a time factor [P. 10].

2. The statute has a plain meaning which does not justify any deference to the interpretation given it by the Secretary of the Department of Health and Human Services ("HHS"). The medically needy respondents are statutorily defined with reference to AFDC income eligibility, and it was the intent of Congress that the needs and means of the AFDC-related medically needy be measured with reference to AFDC [P. 10].

Since an AFDC applicant is determined eligible on a monthly basis, based on one month's income, the statute and legislative history support the judgment below that a medically needy Medicaid applicant must likewise have her eligibility determined on a monthly basis based on one month's income [P. 13].

3. Prior to a series of statutory changes that were made starting in 1981, the Secretary of HHS (the

"Secretary") had been vested with legislative authority to prescribe the standards for State Medicaid income eligibility determinations. That former version of the statute merely required that, pursuant to the Secretary's standards, the medically needy have eligibility rules "comparable" to those of the categorically needy [P. 16].

Under that delegation for defining "comparable" standards the Secretary accommodated the then existing outside parameters of Medicaid eligibility by authorizing States to determine income for periods of up to six months. SSI eligibility, and the Medicaid eligibility that automatically goes with it, were then determined on the basis of quarterly (3-months') income, and separate Medicaid eligibility was available for the three months prior to the month of application. Thus, for the medically needy, the Secretary had to have a rule allowing up to six months' income to be counted in order to accommodate coverage of up to six months, just as six months' coverage was available for categorically needy SSI applicants [P. 18].

4. In 1981 Congress revised the "comparability" language, but it intended to retain the doctrine that the medically needy have their eligibility determined no more restrictively than their categorically needy counterparts. The Secretary ignored this legislative history and authorized States to use more "flexible" standards [P. 19].

In 1981, in the same Act in which it enacted the amended version of 42 U.S.C. § 1396a(a)(10)(C) that the Secretary eventually misconstrued, Congress also mandated for the first time that AFDC and SSI income eligibility determinations be done on a monthly basis. Since the Secretary ignored the stated intent of Congress in amending 42 U.S.C. § 1396a(a)(10)(C), it is no wonder that the Secretary also ignored or overlooked the impact

of the one-month income budgeting requirement for AFDC and SSI [P. 20].

In response to the Secretary's disregard of its stated intent, Congress in 1982 enacted current 42 U.S.C. § 1396a(a)(10)(C)(i)(III), requiring that Medicaid income eligibility for the AFDC-related be determined using the same methodology as AFDC income eligibility. In light of the Secretary's refusal to abide by previous Congressional intent, Congress did not re-delegate legislative authority to the Secretary. This combination of factors requires that no judicial deference be given to the views of the Secretary as set forth in 42 C.F.R. § 435.831 and the *amicus curiae* brief of the United States [P. 20].

5. In enacting 42 U.S.C. § 1396a(a)(10)(C)(i)(III) in 1982 Congress did not intend to validate the six-month rule of 42 C.F.R. § 435.831 or to permit the Secretary to determine Medicaid income eligibility on other than the monthly basis then being used to determine AFDC and SSI income eligibility. The legislative history shows that Congress intended to require that there be at least an identity of treatment between the eligibility criteria for Medicaid and the eligibility criteria for AFDC and SSI. Congress clearly intended to restrict the Secretary's authority to permit variations between the eligibility determinations for Medicaid and those for AFDC and SSI in light of the prior disregard of the intent of Congress evidenced by the Secretary's misinterpretation of the 1981 amendments [P. 21].

The continued existence of 42 C.F.R. § 435.831 permitting six-month income eligibility determinations for Medicaid is not proof of its validity. Since HHS has stated that 42 U.S.C. § 1396a(a)(10)(C)(i)(III) is "self-implementing," Congress cannot be said to have ratified the regula-

tion by failing to repeal it since 1982. Congress likewise has not expressly reaffirmed the six-month regulation either [P. 23].

6. The six-month regulation, 42 C.F.R. § 435.831, cannot be justified as being based on a separate statutory "spend-down" concept authorized under the last clause of 42 U.S.C. § 1396a(a)(17). The "spend-down" simply represents another deduction from income, and since income is computed monthly under 42 U.S.C. § 1396a(a)(10)-(C)(i)(III) so must this deduction for incurred medical bills [P. 25].

The Secretary's regulations have always recognized that determining income eligibility based on net income, the issue here, under 42 U.S.C. § 1396a(a)(10)(C), is different from determining the sorts of medical bills that States need not deduct from income, the issue under the last clause of 42 U.S.C. § 1396a(a)(17). Thus the six-month regulation, 42 C.F.R. § 435.831, cannot be justified pursuant to the last clause of 42 U.S.C. § 1396a(a)(17) [P. 26].

ARGUMENT

POINT I

THE PLAIN MEANING OF 42 U.S.C. § 1396a(a)(10)(C) REQUIRES THAT MEDICAID INCOME ELIGIBILITY BE DETERMINED ON A MONTHLY BASIS

A. The Statute Concerns Determining Income Eligibility

The statute,[8] read in its entirety, prescribes how many months' income the State can count in making a Medicaid eligibility determination based on income. Under Section-

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[8] 42 U.S.C. § 1396a(a)(10)(C)(i)(III) (hereinafter "Section III").

III, the State's plan for its Medicaid program must describe

> the single standard to be employed in *determining income . . . eligibility . . .* and the methodology to be employed in *determining such eligibility,* which shall be the same methodology which would be employed under [SSI or AFDC]. [Emphasis supplied.]

The State's focus on the word "methodology" ignores the rest of the statutory language which makes clear that this section concerns determining income eligibility.

Income, by definition, can only be determined over a stated period of time, and the related statutory provisions for determining income eligibility for AFDC and SSI naturally specify such a time period—one month.[9] That time period is thus incorporated into the requirements of Section III for determining Medicaid income eligibility as well.

B. Income Eligibility For AFDC And SSI Is Determined On A Monthly Basis

The AFDC statute states explicitly for what period income is to be counted in determining income eligibility for that program: States must "determine a family's eligibility for [AFDC] for a month on the basis of the family's income . . . during such month." 42 U.S.C. § 602(a)(13). The SSI statute is similar: "An individual's eligibility . . . for a month shall be determined on the basis of the individual's . . . income, resources, and other characteristics in such month . . . ." 42 U.S.C. § 1382(c)(1).

The statutes covering all three programs, Medicaid, AFDC, and SSI, all refer to determining eligibility on the

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[9] 42 U.S.C. §§ 602(a)(13) and 1382(c)(1), respectively.

basis of income. For the AFDC and SSI programs the statutes explicitly require that income eligibility determinations be based on a single month's income. For Medicaid Section III simply refers to determining income eligibility by referring to the "same methodology" that is used to determine income eligibility for AFDC or SSI. Plainly the Medicaid statute thus requires the use of one month's income, not six months', in determining income eligibility, just as is required for AFDC and SSI.

C. "Income" Is Meaningless Without A Time Component

The State's construction of Section III ignores the common understanding of the word "income." The starting point for construing this statute must be, "as always, the language of the statute." *Heckler* v. *Turner*, ___ U.S. ___, 105 S.Ct. 1138, 1144 (1985). The term "income" has consistently been construed by this Court and other courts as "[involving] time as an essential element in its measurement or definition." *Trefry* v. *Putnam*, 227 Mass. 522, 526, 116 N.E. 904, 907 (1917). As this Court has pointed out, resources, such as assets on a balance sheet, differ from income in that income is "measured by its flow during a period of time." *Eisner* v. *Macomber*, 252 U.S. 189, 206 (1920).

This common sense understanding of the word "income" is exemplified by looking at the situation of respondent McKenna. Saying that she has $531.66 of income says nothing of use. If that were her weekly income she would be "middle class." If that were her daily income she might be well to do. Since it is her monthly income she is poor.

D. Section III Should Be Given Its Ordinary Meaning And Does Not Require Technical Expertise To Be Understood

Section III is rendered meaningless if its reference to the "methodology to be employed in determining such

[income and resource] eligibility" does not encompass the period of time over which such income is measured. The language of the statute should be given its ordinary meaning, *Perrin* v. *United States*, 444 U.S. 37, 42 (1979). As it has in the past in cases dealing with defining "income," the Court should continue to "[refuse] to enter into the refinements of lexicographers" and should instead construe the statute in accord with "the commonly understood meaning. . . ." *Merchants' Loan & Trust Co.* v. *Smietanka*, 255 U.S. 509, 519 (1921).

It is the straightforward nature of the statutory phrase "determining income . . . eligibility" which distinguishes this case from *Connecticut Department of Income Maintenance* v. *Heckler*, ___ U.S. ___, 105 S.Ct. 2210 (1985).[10] There the issue was how to define the term "institution for mental diseases" in the absence of a statutory definition. *Id.*, 105 S.Ct. at 2214. Because of the vagueness of the term the Court gave deference to the Secretary's definition of it, just as it had given deference to the agency in deciding whether or not the "bubble concept" applied to a "stationary source" of pollutants in *Chevron, U.S.A., Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837, 104 S.Ct. 2778 (1984).

Defining the phrase "determining income . . . eligibility" is a far cry from defining a "stationary source" or even an "institution for mental diseases." In this case, unlike *Connecticut* and *Chevron*, technical expertise is not required. Rather, the definition at issue here is like the clear cut definition of a "bank" in *Board of Governors*

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[10] *Connecticut* further differs from this case in that, unlike here, Congress had not previously granted the Secretary legislative authority to establish rules and then withdrawn that authority. *See* Point II(B), *infra*.

of the Federal Reserve System v. *Dimension Financial Corp.*, ___ U.S. ___, 106 S.Ct. 681 (U.S. 1986). There this Court unanimously rejected the Federal Reserve Board's definition of a bank, which conflicted with the definition Congress had provided in the statute. Here Congress has likewise defined how income eligibility for AFDC and SSI is to be determined—on a monthly basis—and it has incorporated those definitions into Section III for Medicaid.

It was, in part, a failure to follow the analytical framework of *Chevron* that led the Second Circuit to err by upholding the six-month regulation in *DeJesus* v. *Perales*, 770 F.2d 316 (2d Cir. 1985), *petition for certiorari docketed* No. 85-6337 (U.S. Feb. 7, 1986). *Chevron* recognizes that where the statute is clear "that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress." *Chevron, U.S.A., Inc.* v. *National Resources Defense Council, Inc.*, *supra*, 467 U.S. at ___, 104 S.Ct. at 2781-2782. Only where the statute is not clear, on its face or analyzed by traditional tools of statutory construction such as legislative history and the context of statutory amendments, does a court even go to the next step of considering an agency's interpretation.

In *DeJesus* the court erred by ignoring the language of the statute, viewed in the context of the 1981-1982 addition of a requirement for determining AFDC and SSI income on a monthly basis and enactment of Section III, and instead deferring to the Secretary. The *DeJesus* court stated that it had to guard against "allowing a *literal reading* of a relatively recent amendment to set at naught the experience of administrators acquired over a score of years." *DeJesus* v. *Perales*, *supra*, 770 F.2d at 321 [emphasis supplied]. Of course, *Chevron* teaches that the "literal reading" of a statute necessarily prevails over a

contrary administrative interpretation no matter how long-standing the agency's interpretation might be. *Accord, SEC* v. *Sloan*, 436 U.S. 103, 117-119 (1978). On the issue of whether the statute is clear the views of the agency are entitled to no greater respect than those of any other litigant.

Respondent here agrees with the Second Circuit that a "literal reading" of the statute supports her position. That should be the end of the inquiry. "Congress . . . did not empower the [Secretary], after the manner of Humpty Dumpty in Through the Looking Glass, to make a regulation . . . by his mere designation." *Adamo Wrecking Co.* v. *United States*, 434 U.S. 275, 283 (1978). This is inherent in the separation of powers between Congress and the executive branch. Moreover, as set forth, *infra*, it is precisely the series of "relatively recent amendment[s]," *DeJesus*, *supra*, that confirm respondent's interpretation.

E. Determining Income Eligibility On A Monthly Basis Accords With The Statutory Definition Of The Medically Needy And The Intent Of Congress

This Court has previously recognized that the income limitations of the related cash program define Medicaid eligibility for those who are not categorically needy AFDC or SSI applicants. *Herweg* v. *Ray*, 455 U.S. 265, 276 (1982) [involving the "optional categorically needy"].[11] The use of the same period for counting income

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[11] This principle is not undercut by *Schweiker* v. *Hogan*, 457 U.S. 569 (1982). There the general requirements for comparable treatment of the medically needy and categorically needy under another statute, 42 U.S.C. § 1396a(a)(17), were overcome by a specific statutory limitation capping the Medicaid income level even if that cap fell below the level for SSI eligibility. Without such a specific statutory exception States cannot use more restrictive rules for determining

for determining Medicaid eligibility as for determining AFDC eligibility is further in accord with the intent of Congress in enacting Medicaid. The medically needy program was intended to cover "persons who would qualify under [*e.g.*, AFDC] if in sufficient need." 111 Cong. Rec. 7216 (1965) (remarks of Rep. Mills). The program requires "that the means test for medical assistance be the same as that applied to applicants for cash benefits under other State public assistance programs." 111 Cong. Rec. 15804 (1965) (remarks of Sen. Ribicoff).

The undisputed fact is that a categorically needy applicant for AFDC (or for SSI) has his or her eligibility determined on a monthly basis, based on a month's income, and receives Medicaid as part of his or her benefits.[12] Such an applicant can receive Medicaid for as little as a single month. For respondents and the class, however, there is no one month Medicaid eligibility. For respondents and the class, eligibility, and the income for determining it, are always measured over six months.

The State's argument in favor of its six-month policy ignores the fact that the methodology for determining income eligibility cannot be isolated from the time factor inherent in measuring income, and it ignores both the statutory language and the Congressional intent defining Medicaid eligibility in relation to income eligibility for cash benefits. The only interpretation of the statute that makes sense and accords with the statutory language and Congressional intent is that adopted by the court below.

Medicaid eligibility than the eligibility rules used for the cash programs. *See Beltran* v. *Myers*, 451 U.S. 625, 629 (1981) (concurring opinion) [four members of this Court agreed on this point; the other five Justices did not reach the issue].

[12] 42 U.S.C. § 1396a(a)(10)(A)(i).

Since AFDC eligibility is determined on the basis of only one month's income, that same methodology must be used to determine Medicaid eligibility based on only one month's income.

POINT II

THE CURRENT VERSION OF 42 U.S.C. § 1396a(a)(10)(C) IS PART OF A SERIES OF STATUTORY CHANGES THAT REQUIRE ONE MONTH INCOME ELIGIBILITY DETERMINATIONS AND THAT HAVE SUPERSEDED 42 C.F.R. § 435.831

The construction of Section III adopted by the courts below, requiring that Medicaid income eligibility be determined based on one month's income, is the only construction that recognizes and is consistent with the series of statutory changes that culminated in the current statutory language. In 1981 Congress repealed the delegation of legislative authority to establish standards for determining income eligibility that it had previously granted to the Secretary under 42 U.S.C. § 1396a(a)(10)(C) [1980]. After the Secretary issued regulations that violated the Medicaid statute as amended in 1981 by Congress, the explicit mandate of Section III was enacted in 1982.

The Secretary's six-month regulation, 42 C.F.R. § 435.831, was adopted before monthly income budgeting was first required for the categorically needy, such as AFDC applicants, so before 1981 the regulation did not need to require monthly income budgeting for the medically needy in order to provide "comparable" standards. Moreover, since from 1974 until early 1982 Medicaid eligibility for SSI applicants could cover their quarterly SSI eligibility period plus the special retroactive three-month coverage period, or up to six months, the Secretary's regulation allowing up to six-month Medicaid budgeting

for the medically needy once made sense. A six-month eligibility period was "comparable" to that used for some of the categorically needy. Congress repealed its delegation of legislative authority to the Secretary, however, and the Secretary issued regulations that violated the Medicaid statute as enacted by Congress. As a result the explicit mandate of Section III was enacted, and the Secretary's regulation, 42 C.F.R. § 435.831 purporting to authorize the State's six-month income determinations, is now invalid as a result of this series of statutory changes.

A. The Former Delegation Of Legislative Authority And The Basis Of The Secretary's Six-Month Regulation Prior To 1981

Prior to 1981 the language of 42 U.S.C. § 1396a(a)(10)-(C) [1980] gave the Secretary greater leeway than current Section III in determining the rules for Medicaid income eligibility. The pre-1981 version of § 1396a(a)(10)-(C) provided that Medicaid income and resource eligibility was to be "determined in accordance with standards prescribed by the Secretary."[13] That language vested legislative authority in the Secretary, whose policies and regulations on the issue were thus entitled to virtually absolute judicial deference. *Schweiker* v. *Gray Panthers*, 453 U.S. 34, 44 (1981); *Batterton* v. *Francis*, 432 U.S. 416, 425 (1977).[14]

The pre-1981 version of the statute merely required that States choosing to cover the medically needy provide Medicaid for those whose income was "insufficient (as determined in accordance with comparable standards)

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[13] The full text of the pre-1981 version is set forth in the Appendix to this brief.

[14] As set forth, *infra*, Point II(B), this delegation of authority to the Secretary was withdrawn by Congress.

. . . to meet the costs of necessary medical and remedial care and services." 42 U.S.C. § 1396a(a)(10)(C)(i) [1980]. Whether or not the pre-1981 reference to "comparable standards" required that they be identical,[15] the delegation of legislative authority authorized the Secretary to harmonize that "comparability" mandate with other aspects of the various public welfare programs as they then existed. The Secretary did this by promulgating 42 C.F.R. § 435.831, which permitted, but did not require, States to determine income over a period of up to six months.

Prior to 1981 the Social Security Act was silent concerning the time period over which AFDC income eligibility was to be determined.[16] For SSI, until April, 1982,

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[15] *Cf. DeJesus* v. *Perales*, 770 F.2d 316, 324 (2d Cir. 1985), *petition for certiorari docketed* No. 85-6337 (U.S. Feb. 7, 1986), holding that "comparable" does not mean "identical" under similar language in 42 U.S.C. § 1396a(a)(17).

[16] The assertions to the contrary in the State's brief (p. 61) and the *amicus* brief of the United States (p. 26, n.15), relying on *DeJesus* v. *Perales*, *supra*, 770 F.2d at 323 n.9, are simply wrong. They cite 42 U.S.C. § 602(a)(8) [1976], a section providing for a monthly disregard of $30 plus 1/3 the remainder of earned income, but that section generally applied only to persons otherwise income eligible for AFDC without application of that disregard. It was not generally used for determining eligibility, and the Secretary successfully defended a constitutional challenge in this Court based on this distinction, *Conner* v. *Richardson*, 400 U.S. 1003 (1971), *aff'g Conner* v. *Finch*, 314 F.Supp. 364 (N.D.Ill. 1970). Less than a year ago the Secretary successfully defended against having to apply the $30 and 1/3 disregard to Medicaid eligibility since it was not applied to AFDC eligibility. *Zilska* v. *Mansour*, Civil No. 79-10093 (E.D.Mich. June 14, 1985), and the Secretary's regulations recognized this distinction also. 45 C.F.R. § 233.20(a)(7)(ii) [1980]. See also *McGraw* v. *Berger*, 537 F.2d 719, 721, 723 (2d Cir. 1976), *cert. denied* 429 U.S. 1095 (1977); S.Rep. No. 97-139, 97th Cong., 1st Sess., at 435, *reprinted in* [1981]

eligibility was generally determined on a quarterly basis.[17]

The Secretary thus had to have in place, prior to the 1982 change from quarterly to monthly income eligibility determinations for SSI, a regulation permitting Medicaid income eligibility determinations to be made based on at least three months' income for the SSI-related so that such Medicaid income eligibility determinations could be "comparable" to those used for SSI. Additionally, such a regulation also served as an outer limit to accommodate whatever variations States might wish to adopt for determining AFDC income eligibility.

The six-month limit of 42 C.F.R. § 435.831 made further sense prior to April, 1982, since the Secretary's regulations for the medically needy, in order to be "comparable" to the eligibility policies for the categorically needy, had to accommodate both quarterly SSI-related income eligibility determinations, *supra*, and a special period of Medicaid eligibility available for the three calendar months prior to the month of application under 42

U.S. Code Cong. & Admn. News 396, 701 ["The $30 and one-third applies only to those already on the rolls . . ."].

Equally inexplicable are their citations to 42 U.S.C. § 602(a)(28) [1976], which only applied "in determining the amount of aid to which an eligible family is entitled." That section did not apply to determining eligibility for AFDC either.

[17] The current monthly income eligibility determination for SSI under 42 U.S.C. § 1382(c)(1) was changed from the prior quarterly computation by Pub.L. No. 97-35, § 2341, 95 Stat. 865 (1981). *See* S.Rep. No. 97-139, 97th Cong., 1st Sess., at 442, *reprinted in* [1981] U.S. Code Cong. & Admn. News 396, 708.

U.S.C. § 1396a(a)(34).[18] The six-month limitation in 42 C.F.R. § 435.831 permitted the maximum coverage span of six months possible from a combination of the quarterly SSI income eligibility determination and the special three months' coverage under 42 U.S.C. § 1396a(a)(34).[19]

B. The Statutory Changes Requiring One Month Income Eligibility Determinations And The Withdrawal Of Legislative Authority From The Secretary

This situation of somewhat undefined statutory requirements for determining income eligibility, coupled with extensive discretion vested in the Secretary, was totally changed by the Ninety-seventh Congress in 1981 and 1982. In 1981 Congress mandated that both AFDC and SSI income eligibility determinations be made on the basis of one month's income. Pub. L. No. 97-35, §§ 2315(a) and 2341, 95 Stat. 855 and 865 (1981).[20] In that same bill Congress revised 42 U.S.C. § 1396a(a)(10)(C) to allow the States moderate flexibility in certain aspects of their Medicaid coverage, unrelated to income eligibility determina-

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[18] In fact, from its inception in the Handbook of Public Assistance Administration (Brief for Petitioner at A15) through September, 1978 (42 C.F.R. § 448.3(c)(4) [1977]), the six-month rule provided for the six months to start with the month services were rendered. Massachusetts follows this policy to date, including any of the three-month retroactive coverage in the six-month budget period. 106 C.M.R. § 506.510. While that has not been explicit since the regulations were recodified in 1978, the recodification made "no substantive changes." 43 Fed.Reg. 45176 (1978).

[19] The current version of 42 C.F.R. § 435.831, slightly differently worded and codified, was expressly stated as implementing both SSI and the mandatory 3-month coverage under § 1396a(a)(34). 38 Fed.Reg. 16309 (1973); 39 Fed.Reg. 9512, 9517 (1974).

[20] The Omnibus Budget Reconciliation Act of 1981 ["OBRA"].

tions. Pub.L. No. 97-35, § 2171(a)(3), 95 Stat. 807 (1981). The Secretary, however, seized upon that "flexibility" as an opportunity to revise the old "comparability" regulations to the point of virtually eliminating them. 46 Fed. Reg. 47976 (1981). The Secretary also ignored the effect of the new requirements that AFDC and SSI income eligibility be determined on a monthly basis.

Congress responded in 1982 by enacting the current stringent "same methodology" requirement of Section III[21] and expressly *not* re-delegating to the Secretary the legislative authority with regard to income eligibility determinations that had previously existed under that section since the Medicaid program's inception. The effect of such an express withdrawal of previously delegated legislative authority was ignored by the courts in *DeJesus* v. *Perales*, *supra*, and *Hogan* v. *Heckler*, 769 F.2d 886 (1st Cir. 1985), *petition for certiorari docketed sub nom Hogan* v. *Bowen*, No. 85-6386 (U.S. Feb. 14, 1986), on which petitioner relies. The failure of those courts to consider this withdrawal of the delegation of legislative authority to the Secretary completely undermines their analyses.

Subsequently Congress has consistently emphasized that the Secretary's interpretation of Section III is incorrect, and the Secretary has ignored Congress' views on that as well. As a result Congress has had to further restrict the Secretary's powers by enacting a "moratorium" on the Secretary imposing any sanctions on States for allegedly violating Section III by using more generous Medicaid budgeting than is used for AFDC or SSI. Pub.L. No. 98-369 § 2373(c), 98 Stat. 1112 (1984). *See also* the proposed Consolidated Omnibus Budget Recon-

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[21] Pub.L. No. 97-248, the Tax Equity and Fiscal Responsibility Act of 1982 ["TEFRA"], § 137(b)(8), 96 Stat. 378 (1982).

ciliation Act of 1985, H.R. 3128, § 9521, H.R. Conf. Rep. No. 99-453, 99th Cong., 1st Sess., at 156 and 552 (1985). Since it is Congress, not the Secretary, that enacts the laws, the Court should follow the expressed intent of Congress and give absolutely no deference whatsoever to the views of the Secretary as to the meaning of Section III.

In this unique situation where the previous delegation of legislative authority has been withdrawn, the necessary counterpoint to the heightened deference previously due under *Batterton* v. *Francis*, 432 U.S. 416, 425 (1977) is to give no deference to the Secretary. Otherwise, under the sort of implicit delegation recognized in *Chevron* and *Connecticut Income Maintenance*, *supra*, the agency could still work mischief by regulation absent the most narrowly drawn statute. Plainly Congress intended to strip the Secretary of the otherwise customary power to reconcile different sections of the statute insofar as Medicaid income eligibility determinations were concerned. Accordingly the Secretary should be accorded no deference on this issue.

C. The Legislative History Demonstrates That 42 C.F.R. § 435.831 Has Been Statutorily Superseded

Nothing in the development of Section III suggests that Congress had any intent to validate the 6-month income counting regulation, 42 C.F.R. § 435.831, or any intent to vest authority in the Secretary to permit States to determine Medicaid income eligibility more restrictively than AFDC or SSI income eligibility is determined.

To the contrary, the legislative history indicates that the medically needy, like respondents, were not to have their eligibility determined more restrictively than their categorically needy counterparts. When Congress in 1981

repealed the former "comparability" language of 42 U.S.C. § 1396a(a)(10)(C)and the language delegating legislative authority to the Secretary, its stated intent was nonetheless to require at least "identical treatment for eligibility criteria . . . between the categorically needy and the medically needy programs." H.R. Conf. Rep. No. 97-208, 97th Cong., 1st Sess., at 971, *reprinted in* [1981] U.S. Code Cong. & Admn. News 1010, 1333.

What led up to the enactment of Section III in 1982 was the HHS response to the 1981 amendments that did precisely the opposite of what Congress intended. HHS issued regulations authorizing States to treat the medically needy more restrictively than the categorically needy in determining income and resource eligibility. 46 Fed. Reg. 47976 (1981). Six days after HHS issued those regulations Congress criticized them as "flatly inconsistent with the statute and the intent of the conferees." 127 Cong. Rec. H7052 (Oct. 6, 1981) (remarks of Rep. Waxman, manager for the House in the conference). HHS did not respond by changing its new regulations in any respect. Since the Secretary ignored the stated intent of Congress by repealing the "comparability" regulations, and then ignored Congressional protests about that repeal, it is hardly surprising that the Secretary also did not amend 42 C.F.R. § 435.831 to respond to the new one-month income eligibility requirements for AFDC and SSI that were part of the same Act.[22]

The result of the Congressional displeasure with the Secretary's attempts to permit States to budget the medi-

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[22] Section 1396a(a)(10)(C) was amended by Pub.L. No. 97-35, § 2171(a)(3), 95 Stat. 807 (1981). One month AFDC income eligibility determinations were required for the first time by § 2315(a) of that act, 95 Stat. 855 (1981), and quarterly SSI income eligibility was changed to monthly by § 2341, 95 Stat. 865 (1981).

cally needy more restrictively than their categorically needy AFDC and SSI counterparts was the enactment of Section III. It plainly requires that the monthly income eligibility determinations newly required for AFDC and SSI also be used for Medicaid. Nothing in the legislative history contradicts the plain language of the statute, and Congress' intent to prevent the Secretary from allowing States to exercise any "flexibility" supports that plain meaning.

The fact that the 6-month provision of 42 C.F.R. § 435.831 is still on the books is also of no help to the State. The views of the Secretary in support of the regulation's validity are plainly not entitled to any extraordinary degree of judicial deference since the delegation of legislative authority was withdrawn. The history of § 1396a(a)(10)(C), and the Secretary's responses to its amendments, in fact show that the Secretary is entitled to no deference whatsoever on this issue.

Likewise the Secretary's own pre-litigation position concerning the effect of Section III on his regulations completely undermines the notion that the six-month regulation continues in effect. Despite the passage of some 3 1/2 years, the disputed 1981 "flexibility" regulations that prompted Congress to enact the current statute have not been repealed or revised. Why? The Secretary took the position that the 1982 TEFRA amendments are "self-implementing" and have superseded the old regulations without need to repeal or revise them. 47 Fed. Reg. 57775, 57776 (1982). Section III[23] is expressly listed by the Secretary as one of those "self-implementing" and superseding statutes. 47 Fed. Reg. 57775 (1982). Thus the continued existence of 42 C.F.R. § 435.831 is no evidence

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[23] Pub.L. No. 97-248, § 137(b)(8), 96 Stat. 378 (1982).

of its validity. Congress cannot be said to have endorsed that regulation simply because it has not expressly referred to it in the 3 1/2 years since Section III was enacted; the Secretary's assertion that the TEFRA changes were "self-implementing" certainly should have led Congress to infer that 42 C.F.R. § 435.831 had been repealed.

The State fares no better by the alternative arguments that Congress either did not intend to affect the 6-month regulation since it failed to expressly refer to it or that Congress affirmed the regulation by expressly referring to it. These arguments are completely contradictory; this contradiction undermines any weight the State seeks to attach to the legislative history to try to avoid the plain mandate of Section III. The failure of Congress to pass a specific revising amendment does not show that Congress ever thought a particular regulation was correct. *SEC* v. *Sloan*, 436 U.S. 103, 119-122 (1978). The case here is even stronger than in *Sloan*, where Congress was specifically advised of the policy in question. *Id.*, 436 U.S. at 119-120. That is not so here. Since Congress was not specifically apprised of this issue, this case is likewise different from those cited by the United States in its *amicus curiae* brief (p. 16).

The State's alternative argument that Congress expressly reaffirmed 42 C.F.R. § 435.831 misreads the legislative history on which it relies. The House Report[24] on TEFRA stated that the bill "reaffirms the financial requirements *previously in effect* for the medically needy

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[24] H.R. Rep. No. 97-757, Part I, 97th Cong., 2d Sess., at 13 (1982). This statement in a committee report of only one house is entitled to little weight in any event since it was neither repeated in the Senate nor in a conference report. *TVA* v. *Hill*, 437 U.S. 153, 192 (1978).

(42 C.F.R. § 435.800-435.845)." [Emphasis supplied.] The State and the Secretary focus on the parenthetical reference to the series of regulations §§ 435.800-435.845, which appears at first glance to include § 435.831, but they ignore the modifying phrase "requirements previously in effect."

42 C.F.R. § 435.831 had not been just "previously" in effect. Since it had never been amended it was on its face apparently in effect all the while. Congress was merely reaffirming so much of the rules "previously in effect" as had been altered by the Secretary, *i.e.*, those requiring that Medicaid income eligibility determinations be "comparable" to those for AFDC and SSI. There was no need to "reaffirm" § 435.831 since the Secretary had not changed it. The committee report is no more an indication that Congress considered 42 C.F.R. § 435.831 than the rest of the legislative history. It does not support the argument of the State and the Secretary that the 6-month regulation was ratified by Congress.

POINT III

42 C.F.R. § 435.831 IS NOT AUTHORIZED BY 42 U.S.C. § 1396a(a)(17)

The State and Secretary fare no better with their argument that the issue here is not about the methodology for determining Medicaid eligibility based on income under Section III, but rather is about the allegedly separate issue of the length of time the State can use in computing the "spend-down" deduction of incurred medical expenses. The concept of the "spend-down," a term which does not appear in either the Social Security Act or the federal Medicaid regulations, cannot be so easily divorced from the computation of income.

> The spend down requirement does not have a life of its own. It must be calculated over the same period that income eligibility [is] calculated under the categorical assistance program.

Brogan v. *Miller*, 537 F.Supp. 139, 144 n.12 (N.D. Ill. 1982).

This is so because the "spend-down" is simply one of many deductions from income used in determining Medicaid income eligibility. The First Circuit erred in *Hogan* v. *Heckler*, *supra*, by ignoring the fact that the "spend-down" is simply another deduction from income. Since income eligibility must be determined on a monthly basis so must the deductions used in determining income eligibility. The Second Circuit recently recognized this despite its decision in *DeJesus* v. *Perales*, *supra*, when it defined the "spend-down" computation as a "methodology" under Section III in *Camacho* v. *Perales*, No. 85-7139, Slip opn. at 7121 (2d Cir. Jan. 24, 1986) (available Feb. 28, 1986 on *LEXIS* Genfed library, USApp. file):

> The decision that a medically needy applicant will first become eligible for Medicaid when, in a given period his Income minus Medical Expenses = Medically Needy Income Level is likewise an example of a methodology . . . . [Slip opn. at 7149.]

The six-month regulation has always been described by HHS as concerning the determination of income, not the "spend-down." It is currently captioned "income eligibility" and refers to the six-month period as the time over which "to compute income." When first proposed, the "spend-down" regulation concerned the "flexible measure of available income" by taking into account medical "costs incurred"[25] and was in a wholly separate subsection[26]

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[25] *Cf.* 42 U.S.C. § 1396a(a)(17).

[26] 45 C.F.R. § 248.21(a)(2) [1969], proposed at 33 Fed.Reg. 12752 (1968) and adopted at 34 Fed.Reg. 1320-1321 (1969).

from the six-month regulation.[27] That pattern of separating the "spend-down" provision and the six-month income determination provision continued until 1980 when what were described as merely "technical corrections" put the six-month rule into the general introduction to 42 C.F.R. § 435.831 and for the first time encompassed the "spend-down" concept as a subdivision of that general rule.[28]

The six-month regulation cannot be justified as being within the powers legislatively delegated to the Secretary under 42 U.S.C. § 1396a(a)(17) for defining the scope of the "spend-down." Again the statutory language does not support the burden the State and Secretary lay on it. The relevant last clause of § 1396a(a)(17) requires that a State's Medicaid plan

> provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs . . . incurred for medical care or for any other type of remedial care . . . .

That section has nothing to do with the issue here of how many months' income is to be counted in determining Medicaid income eligibility. Rather that section states a general proposition that all costs for medical or other remedial care must be offset against whatever income is

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[27] 45 C.F.R. § 248.21(a)(4) [1969], proposed and adopted as above.

[28] 45 Fed.Reg. 24878, 24881 (1980). Prior thereto the 1968 separation of the two subdivisions was maintained consistently through various proposed and final rules and recodifications, 35 Fed.Reg. 8780, 8791 (1970); 36 Fed.Reg. 3860, 3871 (1971); 38 Fed.Reg. 32216, 32219-32220 (1973); 39 Fed.Reg. 35912, 35917 (1974). A variant on the current structure of the regulation was adopted when the regulations were recodified and revised, allegedly without substantive change in 1978. 43 Fed.Reg. 45176, 45215 (1978); under that version the six-month rule was described as a policy for "determining countable income." 42 C.F.R. § 435.831(a) [1978].

otherwise counted, and then that section delegates to the Secretary the power to put limits on those medical or remedial expenses that States can so deduct.

A few examples show how the Secretary has put limits on the deductibility of medical expenses under that authority and how such policymaking differs from the policy that is at issue here. On its face § 1396a(a)(17) suggests that a Medicaid applicant could count any incurred bills, no matter how ancient; the Secretary has so interpreted the statute, but then has limited it slightly by requiring that the bills must still be current obligations. HHS Medical Assistance Manual § 4-30-30.[29] HHS has now proposed under this authority in § 1396a(a)(17) to further restrict the bills that can be counted to those no more than a few months old. 48 Fed. Reg. 39960, 39961 (1983). Likewise HHS has by regulation[30] authorized States to set limits on the amount of health insurance premiums they will deduct.

Such limits on the costs States must take into account under § 1396a(a)(17) are a far cry from the provision of 42 C.F.R. § 435.831 allowing States to determine income eligibility for a six-month period based on six months' income. The six-month regulation here has nothing to do with limitations on what bills can be counted.[31] 42 U.S.C.

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[29] Massachusetts counts only newer bills, its courts having concluded that the Medical Assistance Manual policy is invalid. *Tinkham* v. *Department of Public Welfare*, 11 Mass.App.Ct. 505, 417 N.E.2d 452 (1981).

[30] 42 C.F.R. § 435.831(c)(2).

[31] An example of this distinction is presented in *DeJesus* v. *Perales*, 770 F.2d 316 (2d Cir. 1985), *petition for certiorari docketed* No. 85-6337 (U.S. Feb. 7, 1986). There plaintiffs were going to have sufficient bills from two hospitalizations to qualify for Medicaid, no

§ 1396a(a)(17) simply does not concern the issue presented here of how long the budget period may be in determining Medicaid eligibility.

CONCLUSION

For the foregoing reasons the judgment of the Supreme Judicial Court should be affirmed.

Respectfully submitted,

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matter how long the "spend-down" period was, for their six-month "spend-down" was well below the cost of only one hospital stay. Their problem was not whether the hospital bills could be counted, or whether the bills could be counted months after the fact, both legitimate issues for the Secretary to regulate under 42 U.S.C. § 1396a(a)(17). Rather, their concern was with how many months of their income would be counted in computing their share of the bills.

APPENDIX

APPENDIX

42 U.S.C. § 1396a [1980]

§ 1396a. State plans for medical assistance—Contents

(a) A State plan for medical Assistance must—

* * *

(10) provide

* * *

(C) if medical assistance is included for any group of individuals who are not described in clause (A) and who do not meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under subchapter XVI of this chapter, as the case may be, as determined in accordance with standards prescribed by the Secretary—

(i) for making medical assistance available to all individuals who would, except for income and resources, be eligible for aid or assistance under any such State plan or to have paid with respect to them supplemental security income benefits under subchapter XVI of this chapter, and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical and remedial care and services, and

(ii) that the medical assistance made available to all individuals not described in clause (A) shall be equal in amount, duration, and scope;

* * *

Supreme Court, U.S.
FILED
APR 9 1986
JOSEPH F. SPANIOL, JR.
CLERK

No. 85-632

IN THE
SUPREME COURT OF THE UNITED STATES
October Term, 1985

CHARLES ATKINS, Commissioner
of the Massachusetts
Department of Public Welfare,

Petitioner,

v.

SANTOS RIVERA, Madeline McKenna,
and all others similarly situated,

Respondents.

On Writ of Certiorari
to the Supreme Judicial Court for
the Commonwealth of Massachusetts

REPLY BRIEF FOR THE PETITIONER

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April 1986

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REPLY BRIEF FOR THE PETITIONER

In our main brief, we demonstrated that the Secretary by regulation, which was adopted at the inception of the Medicaid program in 1966 pursuant to an express delegation of authority in the final clause of 42 U.S.C. § 1396a(a)(17), has consistently authorized states to use

a spenddown period of up to six months, and that the great majority of states which have chosen to extend their Medicaid coverage to include the optional medically needy program have done so on that basis. We further demonstrated that the language of the 1982 amendment inserting 42 U.S.C. § 1396a(a)(10)(C)(i)-(III), taken as a whole, could not literally be applied to the spenddown determination, and that the legislative history of the amendment clearly shows that it was not intended to override the Secretary's longstanding regulation (which the House Report expressly reaffirmed), but was directed instead to an entirely different purpose. We argued that the Secretary's interpretation pursuant to a broad grant of authority within an incredibly complicated statute, not having been plainly overridden by

Congress, was entitled to controlling weight. Respondents do not refute these essential points, but they do raise several arguments to which we respond briefly.[1/]

1. The First and Second Circuits were correct (despite Respondents' Brief, Point III) in holding that 42 U.S.C. § 1396a(a)(17) is the source of the Secretary's authority for the six-month spenddown regulation, 42 C.F.R. § 435.831. Hogan v. Heckler, 769 F.2d 886, 892 & n. 12, 902 (1st Cir. 1985), petition for cert. filed sub nom. Hogan v. Bowen, No. 85-6386; DeJesus v. Perales, 770 F.2d 316, 327 (2d Cir. 1985

1/ We refer to "respondents" in the plural because this is a properly certified class action, and the Brief for Respondent McKenna, whose status as class representative is undisputed, is perforce on behalf of the class.

petition for cert. filed, No. 85-6337.[2/]

The final clause of § 1396a(a)(17), which delineates the spenddown concept, specifically gives to the Secretary the authority to "prescribe" the "extent" to which participating states must take incurred medical costs into account in determining medically needy Medicaid eligibility. The six-month rule literally addresses one important aspect of the extent to which states have latitude in taking medical costs into account. It comes within the plain meaning of the express delegation of authority conferred in the statute.

2/ See also Brief for the United States as Amicus Curiae at 12-14; Medicaid Program; Deduction of Incurred Medical Expenses (Spend Down), Notice of Proposed Rule-Making, 48 Fed. Reg. 39960 (Sept. 2, 1983) (specifying § 1396a(a)(17) as the authority for proposed amended spenddown regulations).

Respondents gain nothing from their argument that the six-month rule originally was contained in, and derives its force from, a closely related regulation concerning the availability of income. Respondents' Brief at 26-27. The Secretary also has express legislative authority on that subject, contained in 42 U.S.C. § 1396a(a)(17)(B). The heightened deference to which that delegation of authority is entitled recently has been specifically reaffirmed by this Court. Herweg v. Ray, 455 U.S. 265, 274-75 (1982); Schweiker v. Gray Panthers, 453 U.S. 34, 43-44 (1981).

Since the Secretary's authorization of a six-month spenddown was made (and has been maintained for twenty years) pursuant to an express delegation of prescriptive authority, it is entitled

to great weight. Id. "These principles of deference have particular force in the context of this case." Aluminum Company of America v. Central Lincoln Peoples' Utility District, ___ U.S. ___, 104 S. Ct. 2472, 2480 (June 5, 1984). The statute under consideration is abstruse and complex; the Secretary "has longstanding expertise in the area, and was intimately involved in the drafting and consideration of the statute by Congress;"3/ and "[f]ollowing enactment of the statute, the agency immediately interpreted the statute in the manner now

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3/ As to the agency's intimate involvement, see Wilbur D. Mills, "Building a Better Safety Net," Health Care Financing Review (1985 Annual Supplement) at 1; Wilbur J. Cohen, "Reflections on the Enactment of Medicare and Medicaid," id. at 3-11.

under challenge." Id.[4/]

Respondents' interpretation of § 1396a(a)(10)(C)(i)(III) therefore cannot be correct unless that amendment has implicitly repealed the delegation of authority to the Secretary in § 1396a(a)(17). We demonstrate in ¶ 3, infra, that Congress has not done so. "It is, of course, a cardinal principle of statutory construction that repeals by implication are not favored." Parsons Steel, Inc. v. First Alabama Bank, ___ U.S. ___, 106 S. Ct. 768, 772 (1986).

2. The six-month spenddown regulation was not adopted (despite Respondents

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4/ The Secretary's interpretation thus represents "a contemporaneous construction of a statute by the men charged with the responsibility of setting its machinery in motion, of making the parts work efficiently and smoothly while they are yet untried and new." Id. (citations omitted).

Brief, Point II) under a delegation of authority in § 1396a(a)(10)(C) which has since been repealed. That delegation concerned an entirely different subject.

The provision in question originally read as follows:

> (B) if medical or remedial care and services are included for any group of individuals who are not receiving aid or assistance under any such State plan [of cash assistance] and who do not meet the income and resources requirements of the one of such State plans which is appropriate, as determined in accordance with standards prescribed by the Secretary, provide-- . . .
>
> (i) for making medical or remedial care and services available to all individuals who would, if needy, be eligible for aid or assistance under any such State plan and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical or remedial care or services, and . . ..

42 U.S.C. § 1396a(a)(10)(B), as enacted

in 1965 by 79 Stat. 345, P.L. 89-97, § 121(a) (emphasis added).[5/]

The delegation of authority referred to by respondents, "as determined in accordance with standards prescribed by the Secretary," clearly modifies the determination as to which "one of such State plans . . . is appropriate," and does not relate to the verb "provide" or to the separate subparagraphs which follow.[6/]

5/ The text as amended in 1973 in respects immaterial here and renumbered as 42 U.S.C. § 1396a(a)(10)(C) by P.L. 93-233, § 13(a)(3), is reproduced in the appendix to Respondents' Brief.

6/ The phrasing of the delegation otherwise makes no sense. The key word in the delegation is "determined." It makes sense for the Secretary's authority to govern the determination as to which of the state plans is appropriate. It does not make sense to suggest that the "as determined" clause somehow modifies the verb "provide," or the objects thereof.

This common-sense reading of the statute is confirmed by the legislative history. The House Report described the original version of this section as follows:

> (B) if the plan under title XIX includes medical assistance for any group of individuals who are not recipients under any such plan and do not meet the State's income and resource requirements under the one of such plans which, as determined in accordance with standards prescribed by the Secretary, is appropriate, provide--
> . . .

H.R. Rep. No. 213, 89th Cong., 1st Sess. 184 (1965) (emphasis added). The Senate Report is practically identical:

> (B) if the plan under title XIX includes medical or remedial care and services for any group of individuals who are not recipients under any such plan and do not meet the State's income and resource requirements under the one of such plans which, as determined in accordance with standards prescribed by the Secretary, is appropriate, provide (except as to care and services described in section 1905 (a)(4) or 1905 (a)(14)) -- . . .

S. Rep. No. 404, 89th Cong., 1st Sess., Pt. I, reprinted in 1965 U.S. Code Cong. & Admin. News at 2145-46 (emphasis added).7/

Since this express delegation of authority concerned only the determination as to which state cash assistance plan was the appropriate reference point for

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7/ Respondents' argument also is premised upon a misinterpretation of the term "comparable standards." The "standards" referred to in subparagraph (i) were standards of need, i.e., income and resource levels; moreover, the comparability required was only among the various medically needy groups. See Schweiker v. Hogan, 457 U.S. 569, 573-74 n. 6 (1982); S. Rep. No. 404, 89th Cong., 1st Sess., pt. 1, 77, reprinted in 1965 U.S. Code, Cong. & Admin. News at 2017; H.R. Rep. No. 213, 89th Cong., 1st Sess. 67 (1965); R. Stevens & R. Stevens, Welfare Medicine in America: A Case Study of Medicaid (1974), at 63; Reply Brief for the Appellant at 6-7, Schweiker v. Hogan, No. 81-213 (U.S. (March 1982). This phrase did not extend, as respondents would have it, to the rules for making financial eligibility determinations, nor did it require comparability between the categorically and the medically needy.

particular groups of medically needy applicants, it is immaterial to this case (and also was not an expression of displeasure with the Secretary) that Congress in 1981 deleted both the underlying substantive provision (in the interest of according greater flexibility to states) and the associated delegation of authority along with it.[8/]

8/ The suggestion that the Secretary's six-month spenddown rule prior to 1981 was intended to "accommodate[ ] the then existing outside parameters of Medicaid eligibility," Respondents' Brief at 6, 18, has no basis. The Secretary's promulgation of the six-month rule was not done to accomodate the respondents' hypothetical three-month SSI budget period plus three-month retroactive Medicaid coverage. SSI was not enacted until six years later. Moreover, the Secretary provided that eligibility for the three-month retroactive period must be "separately determined; i.e., by applying a quarterly medically needy income level . . . ." Department of Health and Human Services, Medical Assistance Manual § 4.30.30(B)(1)(b)(1) at 13 (1976); see

(footnote continued)

This delegated authority had no connection to the six-month spenddown regulation, and its repeal has no bearing here.9/

(footnote continued)

also 48 Fed. Reg. 39959-61 (Sept. 2, 1983). Also, the original language of the rule encouraged a prospective budget period of "preferably no more than three months." Department of Health, Education and Welfare, Handbook of Public Assistance Administration §§ D-4220(A)(4), D-4230(4) (1966); see DeJesus, 770 F.2d at 323, n. 8. Finally, the Secretary has never applied the rule as an "outer limit." Under such an approach, the length of the budget period would have depended, not upon any determination by the state, but upon the characteristics of each applicant. Such a variable period clearly does not comport either with the intent of the Secretary's regulations or with the practice of the States prior to OBRA.

9/ Moreover, respondents' suggestion that Congress was motivated to withdraw the delegation by HHS' misinterpretation of OBRA cannot be correct, since the withdrawal was part of OBRA itself. The dynamics of the interaction between Congress and the Secretary in 1981 and 1982 prove simply that when Congress disapproves of the Secretary's financial eligibility regulations, it is not hesitant

(footnote continued)

3. The definition of income is not the issue in this case (despite Respondents' Brief, Point I), nor is it especially important to the proper resolution of the issue. The issue is whether a six-month spenddown under § 1396a(a)-(17) is prohibited by the "same methodology" requirement of § 1396a(a)(10)-(C)(i)(III). The proper resolution of this issue requires consideration of the language of § 1396a(a)(10)(C)(i)(III) in its entirety. Respondents fail even to address the plain fact that the mandatory

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(footnote continued)

to take corrective action. When Congress took such action in 1982, it expressly endorsed the six-month spenddown regulation, see H.R. Rep. No. 757, Part I, 97th Cong., 2d Sess. 13 (1982), which was adopted pursuant to authority conferred in § 1396a(a)(17) which has never been withdrawn.

datory language of that provision -- "which shall be the same methodology which would be employed under the appropriate State plan" -- literally cannot be applied to encompass the spenddown determination. See Brief for the Petitioner at 32-34.

"First, always, is the question whether Congress has directly spoken to the precise question at issue." Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 104 S. Ct. 2778, 2781 (1984). Congress has not done so in § 1396a(a)(10)(C)(i)(III), or at least not favorably to the respondents. The terms "methodology" and "income eligibility" are not defined in Title XIX, nor are their scope and application to the spenddown plainly addressed by § 1396a(a)(10)(C)(i)(III). It is not

§ 1396a(a)(10)(C)(i)(III), but the final clause of § 1396a(a)(17), that is specifically addressed to the determination of how persons having incomes higher than the medically needy income standard -- i.e., who are ineligible because of their income -- may still qualify for Medicaid on the basis of the cost of their medical care.10/

10/ In determining whether § 1396a(a)(10)(C)(i)(III) encompasses and trammels the spenddown determination of § 1396a(a)(17), the two provisions must be read together. Herweg v. Ray, 455 U.S. 263, 276-77 (1982); Fullington v. Shea, 320 F. Supp. 500, 504-05 (D. Colo. 1970), aff'd summarily, 404 U.S. 963 (1971); Duparquet Co. v. Evans, 297 U.S. 216, 218 (1936). Indeed, § 1396a(a)(17), as the section specifically dealing with the medically needy spenddown, is of greater force. See Clifford F. MacEvoy Co. v. United States, 322 U.S. 102, 107 (1944); Hogan v. Heckler, 769 F.2d at 902. See also p. 7, supra.

Whereas § 1396a(a)(10)(C)(i)(III) is directed to areas of the eligibility determination common to the categorical cash programs and to Medicaid, the spenddown of medical costs for medically needy eligibility is entirely foreign to AFDC or SSI. It is directed to the fundamental difference that the categorically needy lack income to meet their basic needs for maintenance as determined in the context of the cash welfare programs, while the medically needy have income in excess of such needs -- and yet may qualify for Medicaid due to the cost of medical care which they require. As Judge Friendly explained:

> In Medicaid lingo, the spend-down is not part of the "standard to be employed in determining income and resource eligibility." That standard, so far as concerns income, is whether an applicant's monthly income after deduction of various expenses (other than medical expenses) and disregards

> is not more than the Medicaid income level set by the state. The spend-down is not part of this standard; rather, it is the method by which a family that does not meet the standard can nonetheless bring its excess income down to the level required for inclusion in the Medicaid program.

DeJesus v. Perales, 770 F.2d at 326.[11]/

The respondents urge, however, that the spenddown is "simply another deduction" from income, and on this basis is subject to the "same methodology" requirement. Respondents' Brief at 8, 26. This view of the spenddown fundamentally

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11/ Contary to Respondents' Brief at 12-13, DeJesus did not conclude that a "literal reading" of § 1396a(a)(10)-(C)(i)(III) would include the length of the spenddown period. The "literal reading" excerpt is from a general, introductory comment, 770 F.2d at 321. When addressing the merits of the case the court stated, with respect to the precise question here: "This is a problem as to which the Act seems to be silent." Id. at 327.

distorts its special role and particular purpose in determining an applicant's need for medical assistance not just in terms of whether his income is sufficient to meet his basic maintenance needs, but by reference to the cost of necessary medical care as well. See, e.g., S. Rep. No. 404, supra at 79, 1965 U.S. Code Cong. and Admin. News at 2019.[12/]

12/ Section 1396a(a)(17) itself distinguishes between disregards from income, which are treated in § 1396a(a)(17)(B), and the spenddown determination, which is specified in the final clause of the section. The spenddown concept was highlighted within Congress in 1965 as one of the most important aspects of the Medicaid program. See S. Rep. No. 404, Part 1, 89th Cong., 1st Sess., 10, 78-79, reprinted in 1965 U.S. Code, Cong. & Admin. News 1943 at 1951, 2018-19, H.R. Rep. No. 213, 89th Cong., 1st Sess. 10, 68 (1965) (which also describes this determination in annual terms). It has always been an extra step, considered only when an applicant has income in excess of the income standard. See, e.g.,

(footnote continued)

Quite apart from its erroneous premise, respondents' proposition cannot be squared with the plain meaning of the statutory language, particularly the word "same" and the entire phrase, "which would be employed under the appropriate State plan." See Brief for the Petitioner at 32-34. If by "income eligibility" Congress meant to include the determination of net income in the sense of eligibility after incurred medical expenses are taken into account, then § 1396a(a)(10)(C)(i)(III) is internally inconsistent. The methodologies for

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(footnote continued)

42 C.F.R. § 435.831 (1985); 42 C.F.R. § 448.1(a)(2)(ii) (1977); Department of Health & Human Services, Medical Assistance Manual § 4-30-30(B)(1)(d) at 16 (1976); Mass. G.L. c. 118E, § 10.

counting, excluding, deducting and disregarding items in the calculation of net income under AFDC and SSI do not permit the deduction of incurred medical costs. The state cannot use the same methodologies which would be employed under the AFDC plan or in SSI and include a spenddown within the compass of the requirement at the same time.

Respondents argue, in effect, that this Court should ignore the fact that the spenddown is completely different from AFDC and SSI and focus only upon its length. If the statutory language -- which encompasses what types of income and deductions to include, see Brief for the United States as Amicus Curiae at 20; Brief for the Petitioner at 31-32 -- includes any part of the spenddown, it includes those irreconcilable areas of

difference; but it does not clearly and unambiguously extend to budget periods (let alone spenddown periods).[13] A budget period applies at least as much to the determination of the income standard to be applied[14] as it does to the

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13/ Massachusetts by regulation measures income for the medically needy, for determining eligibility against the income standard, in monthly terms. 106 C.M.R. §§ 505.320, 506.410. It also specifies a six-month budget period, id. § 505.300, which appears to be of little practical significance except at the spenddown stage (as to which, see id. § 506.510). In Hogan v. Heckler, supra, 769 F.2d at 888-89, the First Circuit concluded that the state effectively applied a one-month budget period to those medically needy applicants who qualified without a spenddown. There was no evidence on this subject in Hogan, and none below in this case. In any event, as the First Circuit recognized, there would be no inconsistency between using different periods for the determination of income eligibility and of the spenddown liability.

14/ The income standard officially is an annual amount, see 42 U.S.C. § 1396b(f), and is so reported in the state plan.

determination of net countable income and, to the extent applicable, the spenddown of excess income through incurred medical costs.[15/] In any event, conforming the spenddown period to the budget period of the categorical programs would not remove the conflict inherent in trying to reconcile "same methodology" with any spenddown determination at all.

Respondents ultimately take the position that "same" does not mean what it says, asserting somewhat cryptically that

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15/ See Morris v. Morrow, 783 F.2d 454, 462 (4th Cir. 1986) ("A methodology provides an amount which must then be adjusted by the budget period employed by the state and which is then applied against a standard for that budget period to determine eligibility."); Camacho v. Perales, No. 85-7139 (2d Cir. 1986) (slip op. at 7150) (questions of "how long" relate to standards not methodologies). Despite Respondents' Brief at 26, Camacho does not hold that the spenddown is a methodology for determining income eligibility, see slip op. at 7149-50.

"same" -- the most likely candidate in the statute for a "plain meaning" -- should instead be interpreted to mean "at least" the same. Respondents' Brief at 7, 22.[16/] Amici supporting respondents also argue that "same" does not mean what it says. Brief for Susan Reed et al.[17/] But this approach, of

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16/ The legislative history which they cite in support of this proposition, however, does not contain any such qualifier. See H.R. Conf. Rep. No. 97-208, 97th Cong. 1st Sess. 971, reprinted in 1981 U.S. Code Cong. & Admin. News 1010, at 1333. In addition, it is clear from the legislative history of TEFRA that the reference to "eligibility criteria" in Conf. Rep. 97-208 meant only substantive, not financial, eligibility criteria. See H.R. Rep. No. 757, Part I, 97th Cong., 2d Sess. 13 (1982).

17/ There is nothing in the language or legislative history of § 1396a(a)(10)-(C)(i)(III), however, which supports the "no more restrictive" gloss which they advance. Also, they misread 42 C.F.R. § 435.401(c), which governs substantive,

(footnote continued)

course, requires going beyond the "plain meaning" on the face of the statute. And if "same" is not a clear statement

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(footnote continued)

not financial, eligibility. This regulation stems from the original requirement that medically needy coverage extend to "all individuals who would, if needy, be eligible" for cash assistance, 79 Stat. 345, 42 U.S.C. § 1396a(a)(10)(B)(i) (quoted at p. 8, above) (subsequently amended in immaterial respects and moved to § 1396a(a)(10)(C)(i) by P.L. 93-233, § 13(a)(3); later deleted by OBRA, § 2171(a)(3)). It originally was prefaced: "Except for need . . .," 45 C.F.R. § 248.10(c)(3) (1971). This later became: "Except for financial eligibility . . .," see, e.g., 42 C.F.R. § 448.2(b) (1977). The present language was the result of a reorganization of the Medicaid regulations in which "[n]o policy changes have been made." 43 Fed. Reg. 45176 (Sept. 29, 1978). Its "no more restrictive" slant derives simply from the fact that Title XIX permits eligibility on a broader substantive basis than the underlying categorical programs. See 42 U.S.C. § 1396a(a)(10)(A)(ii). Of course, the petitioner disputes any suggestion that the spenddown is "more restrictive," no matter what its length, in the first place.

of congressional intent, it certainly cannot be concluded that the much more indefinite language "methodology for determining income eligibility" has a scope in relation to the length of a spenddown period which has been directly, clearly and unambiguously addressed by Congress.18/

The context of the enactment of § 1396a(a)(10)(C)(i)(III) and the legislative history are set forth at length in the Brief for the Petitioner. Respondents do not dispute that since the inception of Medicaid HHS has permitted states to use a budget period and a

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18/ The petitioner's position is that "same" should be interpreted in accordance with the legislative history of § 1396a(a)(10)(C)(i)(III) to mean "pre-OBRA." See H.R. Rep. No. 97-757, Pt. I, 97th Cong., 2d Sess. 13 (1982). But see Camacho v. Perales, supra, No. 85-7139 (2d Cir. 1986) (slip op. at 7142-47) ("same" means what it says; rejecting a "no more restrictive" gloss).

spenddown of up to six months, pursuant to which most states choosing to have a medically needy program used a six-month period; and that to require a one-month spenddown would have represented a very significant change to the program, imposing a substantial economic burden upon at least 23 states and the District of Columbia or requiring a significant reallocation of resources by those jurisdictions. There is no suggestion in the legislative history of any congressional intent to require any such change; nor does the legislative history contain any criticism of the Secretary's six-month rule. Instead, the legislative history is clear that Congress enacted § 1396a(a)(10)(C)(i)(III) only to correct HHS' misunderstanding of § 2171(a)(3) of OBRA, and intended to reinstate the prior

regulatory scheme, a scheme in which six-month spenddowns abounded (side-by-side with monthly AFDC and quarterly SSI eligibility determinations). See DeJesus, 770 F.2d at 327; Hogan v. Heckler, 769 F.2d at 901. The House Committee Report, H.R. Rep. No. 97-757, Pt. I, 97th Cong., 2d Sess. 13 (1982), graphically pinpoints this limited purpose, and expressly endorses the six-month spenddown regulation; it is an "authoritative source" of Congressional intent. Garcia v. United States, ___ U.S. ___, 105 S. Ct. 479, 483 (1984).

4. Respondents (and amici supporting them) more generally misapprehend the context which bears upon the congressional intent in enacting the "same methodology" requirement.

In enacting Medicaid in 1965, Congress treated the categorically needy more favorably than the medically needy; and it did so because the former are the most needy group. Schweiker v. Hogan, 457 U.S. 569, 572-73 (1982); see also id. at 578-80 (similar intent in the 1967 amendments). The six-month spenddown is consistent with this approach because, in the context of voluntarily expanding the state's Medicaid program beyond the categorically needy, it allocates the state's resources to the most needy of potentially eligible applicants. While we certainly do not deny that those who narrowly fail to qualify under the six-month spenddown are nonetheless needy,[19/] it also can hardly be denied

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19/ Despite the hyperbole of the Brief Amici Curiae of Gray Panthers Advocacy

(footnote continued)

that those who are targeted by the six-month spenddown, whose medical bills exceed their excess income over a six-month period, are generally in greater need.20/

The imposition of a one-month spend-

(footnote continued)

Committee, et al., the point in the Brief for the Petitioner at 67 n. 41 was simply that the six-month period was consistent with a congressional concern expressed in the 1967 debates. By the same token, the Gray Panthers' description of hardships, in this complex and difficult area of social policy, is properly addressed to Congress -- or to the Massachusetts legislature. In those states with no medically needy program, the individuals they describe -- and many in greater need -- are automatically ineligible.

20/ As the Brief for the United States as Amicus Curiae at 18 illustrates, any effort to draw lines among the needy is difficult and subject to criticism, including a one-month spenddown which involves inequities of its own.

down, while benefitting some medically needy applicants or recipients, would doubtless require a reallocation of resources through, e.g., the state's contracting its range of covered services, lowering its medically needy income standard or restricting its coverage to less than all medically needy groups -- all areas, like the length of the spenddown period, in which Congress has given flexibility to the States. Such adjustments would adversely affect those who presently qualify for Medicaid.21/

21/ See Brief for the United States as Amicus Curiae, at 16-18. The state continues to explore ways of reducing hardship from the credit problems of those with regularly recurring medical expenses in excess of their monthly excess income. See Hogan v. Heckler, 769 F.2d at 891, n. 10. Raising the income standard appears to be one effective means to this end. See Mass. St. 1985, c. 140 (item 4402-5000) (providing that the Medicaid

(footnote continued)

In enacting OBRA §§ 2315(a) and 2341(a) (requiring monthly budgeting and retrospective accounting in AFDC and SSI, respectively), Congress was motivated only by considerations of accuracy and cost-saving within AFDC and SSI.[22] There is no merit to respondents' suggestions (Respondents' Brief at 6-7, 19-23)

(footnote continued)

standard for a single individual be set, at state expense, above the limit of 42 U.S.C. § 1396b(f), to match the income level for an individual SSI recipient (plus the optional state supplement), thus increasing the need standard from $383 to $440 per month, and decreasing the spenddown over a six-month period by $342).

22/ Respondents argue that monthly budget periods for AFDC were not required prior to OBRA. We submit they are incorrect; but our point, which respondents do not appear to deny, was that this was the universal practice. See DeJesus, 770 F.2d at 323, n. 9; S. Rep. No. 97-139, 97th Cong., 1st Sess. 440, reprinted in 1981 U.S. Code, Cong. & Admin. News 396, at 706.

that the congressional criticism of HHS' implementation of OBRA § 2171(a)(3) extended to HHS' "failure" to incorporate OBRA §§ 2315(a) and 2341(a) into the Medicaid context. The plain fact is that Congress' criticisms were focused specifically upon HHS' response to § 2171(a)(3), and have never extended to the implementation of these other sections or to the continued existence of the six-month spenddown regulation. See H.R. Rep. 757, Pt. I, 97th Cong. 2d Sess. 13 (1982); 127 Cong. Rec. 23358 (Oct. 6, 1981) (remarks of Rep. Waxman).[23/] The six-month spenddown is consistent

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23/ Contrary to Respondents' Brief at 23-24, HHS has made very clear in the public record its view that TEFRA did not affect the six-month spenddown authorization. See Medicaid Program; Deduction of Incurred Medical Expenses (Spend Down), Notice of Proposed Rule-Making, 48 Fed. Reg. 39959, 39960-61 (Sept. 2, 1983).

with the essential Congressional purpose underlying both OBRA and TEFRA, which emphasized cost-saving and granted flexibility to States to achieve it.24/

5. Respondents say (at 4, n. 7) that they do not rely upon their claim under the "comparable standards" clause of 42 U.S.C. § 1396a(a)(17); but that argument -- in the form of the theme that the statute has always contained a "no more restrictive" requirement -- in fact per-

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24/ Cf. Senator Dole's opening statement in the Senate debate on TEFRA: "In reducing spending, the Finance Committee sought to improve administration of programs and focus assistance more precisely upon those who are most in need." 128 Cong. Rec. S8645 (daily ed., July 19, 1982) (middle column) (emphasis added).

vades their brief.[25/]

The § 1396a(a)(17) claim is properly before this Court. It was asserted in the Complaint and in the Intervenor's Complaint (J.A. 21, 44); it was exten-

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25/ This theme appears especially in the argument at Point IIA that the Secretary's six-month regulation prior to OBRA was an attempt to be consistent with such a mandate (but see n. 8, supra), and in the argument at IIC that Congress intended to retain a "no more restrictive" requirement when enacting OBRA (but see n. 16, supra). The theme is linked to § 1396a(a)(17) specifically in Respondents' Brief at 13, n. 11. Contrary to the assertions there, Schweiker v. Hogan, 457 U.S. 569, 587-88 (1982), specifically held that 42 U.S.C. § 1396b(f) was consistent with, and not an exception to, § 1396a(a)(17). Also, Beltran v. Myers, 451 U.S. 625 (1981), was not brought under the "comparable standards" provision of § 1396a(a)(17), as was respondents' claim in this case, but under a different provision, § 1396a (a)(17)(B). See 451 U.S. at 626, n 1. That case involved transfer-of-assets rules that violated the non-financial eligibility provision of § 1396a(a)(10)-(C)(i), and 42 C.F.R. § 435.401(c) promulgated thereunder. See n. 17, supra; Fabula v. Buck, 598 F.2d 869, 872-73 (4th Cir. 1979).

sively briefed by both parties in the trial court and the Supreme Judicial Court; it was encompassed within the question presented in the Petition for Certiorari; and the respondents in their Brief in Opposition indicated an intention to rely upon § 1396a(a)(17) in defense of the judgment. Moreover, the petitioners in DeJesus v. Perales, No. 85-6337, and in Hogan v. Bowen, No. 85-6386, both of whom are represented by counsel for the respondents here, asserted (in the respective Petitions for Certiorari, at i) that the issue was presented in this case in this Court.

If respondents have waived the claim we have no objection. But we do object to respondents' suggestion, if such it be, that the issue be preserved for remand. Such a result would extend, rather than resolve, uncertainty as to the

validity of the six-month spenddown. Moreover, once the Court decides that § 1396a(a)(17) delegates authority to the Secretary pursuant to which the six-month regulation was properly adopted, the respondents' argument based upon the initial clause of § 1396a(a)(17) necessarily falls. The fundamental differences between the categorically needy and the medically needy, which are embodied in the spenddown clause and are at the heart of why the "same methodology" requirement is not transgressed here, are equally applicable to a like resolution of the § 1396a(a)(17) claim. Resolution of the "same methodology" claim will require an understanding of § 1396a-(a)(17), so it simply makes sense to resolve both claims at the same time.

For the foregoing reasons and the

additional reasons set forth in the Brief for the Petitioner, the judgment of the Supreme Judicial Court should be reversed.

Respectfully submitted,

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April 1986

Supreme Court, U.S.
FILED
JAN 31 1986
JOSEPH F. SPANIOL, JR.
CLERK

No. 85-632

In the Supreme Court of the United States

OCTOBER TERM, 1985

CHARLES ATKINS, COMMISSIONER,
MASSACHUSETTS DEPARTMENT OF PUBLIC WELFARE,
PETITIONER

v.

SANTOS RIVERA, ET AL.

ON WRIT OF CERTIORARI TO THE SUPREME JUDICIAL COURT OF MASSACHUSETTS

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONER

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QUESTION PRESENTED

Whether a regulation of the Secretary of Health and Human Services that permits states participating in the Medicaid program to use up to a six-month period for computing the excess income an applicant must spend on medical care before qualifying for Medicaid is arbitrary, capricious or otherwise unlawful.

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BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONER

INTEREST OF THE UNITED STATES

Medicaid is a joint federal-state program "providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons." *Harris* v. *McRae*, 448 U.S. 297, 301 (1980). In developing plans for administering the Medicaid program, states are given discretion to determine who will receive Medicaid assistance as well as the kinds of assistance provided. State Medicaid plans, however, must comply with requirements imposed by the Act and by the Secretary of Health and Human Services. 42 U.S.C. 1396a.

The United States has a significant interest in the resolution of this case. The Supreme Judicial Court of Massachusetts held that the Commonwealth of Massachusetts violated the Medicaid Act by using a six-month period for determining the excess income that an applicant must spend on medical care before

qualifying for Medicaid. The court held that Massachusetts must use a one-month period. Massachusetts' choice of a six-month period, however, is specifically authorized by a regulation adopted by the Secretary at the inception of the Medicaid program. See 42 C.F.R. 435.831. Presently, some 29 states participating in the Medicaid program use other than a one-month period.

In the Secretary's judgment, the regulation authorizing states to select up to a six-month period furthers substantial policies that underlie the Medicaid program. It allows participating states the choice of targeting their limited financial resources at the most needy individuals and eases the administrative burdens placed on the states. The decision below, by invalidating the Secretary's longstanding regulation, substantially disrupts the operation of the Medicaid program. This result, if upheld by this Court, would increase the cost of participating in that aspect of the Medicaid program at issue in this case—a program that is wholly voluntary for the states—and would thereby raise the prospect that, rather than incur these added expenses, states will curtail the scope of covered services, restrict eligibility, or even withdraw from the program altogether.

STATEMENT

1. Congress established the Medicaid program in 1965 "for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons." *Harris* v. *McRae*, 448 U.S. 297, 301 (1980); see *Schweiker* v. *Gray Panthers*, 453 U.S. 34, 36 (1981). As a cooperative federal-state program,[1] Medicaid

[1] Both federal and state funds are used to finance the program. See 42 U.S.C. 1396b.

leaves the decision whether to participate entirely to the discretion of each state. Once that initial decision has been made, states electing to participate must comply with requirements imposed by the Act and by the Secretary of Health and Human Services. See 42 U.S.C. 1396a; *Gray Panthers*, 453 U.S. at 37.

Individuals covered by certain cash assistance programs—Supplemental Security Income for the Aged, Blind, and Disabled (SSI) (42 U.S.C. 1381 *et seq.*) and Aid to Families with Dependent Children (AFDC) (42 U.S.C. 602 *et seq.*)—automatically qualify for Medicaid. Thus, states that choose to participate in the Medicaid program are required to provide Medicaid to these persons, termed the "categorically needy." See 42 U.S.C. 1396a(a)(10)(A)(i); 42 C.F.R. 435.4, 435.110(a), 435.120(a).[2] At its op-

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[2] When Medicaid was enacted in 1965 there was no SSI program. Rather, there were three separate state-administered programs for the aged, blind, and disabled. See 42 U.S.C. (1970 ed.) 301 *et seq.* (Old Age Assistance); 42 U.S.C. (1970 ed.) 1201 *et seq.* (Aid to the Blind); 42 U.S.C. (1970 ed.) 1351 *et seq.* (Aid to the Permanent and Totally Disabled). In 1972, Congress replaced these programs with SSI. Pub. L. No. 92-603, Tit. III, 86 Stat. 1465, codified at 42 U.S.C. 1381 *et seq.* See *Gray Panthers*, 453 U.S. at 38.

Under the SSI program the federal government sets the standard of need, which often is much higher than the state standards set under the former state-run programs. Thus, with the enactment of the SSI program, it was easier to qualify for SSI, and Medicaid, since these people were now considered categorically needy. See *Gray Panthers*, 453 U.S. at 38. Congress feared that in some states this would lead to a dramatic increase in the number of persons who automatically qualify for Medicaid and that, faced with this fiscal burden, some states would withdraw from the Medicaid program. To avoid this problem Congress "offered what has become known as the '§ 209(b) option.'" *Gray Panthers*, 453 U.S. at 38; see 42 U.S.C. 1396a(f). This gives states the choice of providing Medicaid only to those SSI recipients who would have been

tion, a participating state may also provide coverage to other "less needy" individuals. See H.R. Rep. 213, 89th Cong., 1st Sess. 66 (1965); 42 U.S.C. 1396a (a)(10)(C). In general, these are people who would otherwise qualify for SSI or AFDC except that their income exceeds the levels set for these categorical assistance programs. See *Schweiker* v. *Hogan*, 457 U.S. 569, 572-573 (1982). They are referred to as the "medically needy." See *ibid.*; 42 C.F.R. 435.4.[3] The medically needy may qualify for Medicaid only if they incur medical expenses that reduce their income to the Medicaid eligibility income standard. See 42 U.S.C. 1396a(a)(17); 42 C.F.R. 435.831(c).[4]

2. The same initial steps are used for determining the Medicaid eligibility of the medically needy as are used for determining eligibility for SSI and AFDC assistance. See *Hogan* v. *Heckler*, 769 F.2d 886, 888 (1st Cir. 1985). First, gross income is calculated.

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eligible for Medicaid under the state standards in existence on January 1, 1972—*i.e.*, prior to the enactment of the SSI program. Those who receive SSI but fail to meet the preexisting state standards may qualify for Medicaid by spending their excess income on medical care. See *Gray Panthers*, 457 U.S. at 39 n.5. Massachusetts has not elected to limit coverage under Section 209(b) (86 Stat. 1389).

[3] This group may be subdivided into the "AFDC-related medically needy" and the "SSI-related medically needy," depending on the type of assistance for which the recipient would qualify were it not for the excess income.

[4] The income eligibility standard for the medically needy may not exceed 133⅓% of the highest payment made by the state under the state's AFDC program. See 42 U.S.C. 1396b(f)(1)(B)(i); 42 C.F.R. 435.811(c); *Schweiker* v. *Hogan*, 457 U.S. at 576-580. Thus, a person whose income falls between the AFDC eligibility standard and the Medicaid standard would qualify for Medicaid without incurring any medical expenses. 42 C.F.R. 435.831(b). The present case does not involve persons in that situation.

This may include money earned by the applicant, as well as by a third party such as a spouse or a parent. See 42 C.F.R. 435.821-435.823. Next, various deductions are subtracted from the gross income to arrive at "countable income." See 42 C.F.R. 435.831(a); 106 C.M.R. 505.200, 506.100-506.200.[5]

Up to this point there is no difference between the computations for determining eligibility for SSI, AFDC and Medicaid. For example, the deductions from income for a medically needy applicant must be the same as those allowed to applicants for the corresponding cash program, SSI or AFDC. See 42 C.F.R. 435.831(a). However, because the medically needy possess income above the Medicaid eligibility standard, determination of their eligibility involves an extra step not applicable to SSI or AFDC.

As noted above, before medically needy applicants qualify for Medicaid they must incur medical expenses that reduce their income ("spend down") to the Medicaid eligibility standard. This "spend down concept was incorporated into the Medicaid Act at its origin." *Winter* v. *Miller*, 676 F.2d 276, 277 (7th Cir. 1982); see also 42 U.S.C. 1396a(a)(17); H.R. Rep. 213, *supra*, at 68; S. Rep. 404, 89th Cong., 1st Sess. 78-79 (1965). Since the first Medicaid regulations were adopted in 1969 (45 C.F.R. 248.21(a)(4) (1970) (now 42 C.F.R. 435.831)), the Secretary has permitted states to compute the excess income that must be spent on medical care over a period of time up to six months. This period is referred to as the "spend down period."

3. Massachusetts is one of 34 states (along with the District of Columbia, Puerto Rico, and the Virgin Islands) that have elected to participate in the Med-

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[5] "C.M.R." refers to the Code of Massachusetts Regulations (Mass. Admin. Code tit. 106 (1983)).

icaid program and to provide coverage for the medically needy. Mass. Ann. Laws ch. 118E, § 1 (Law. Co-op. 1975). Like 29 of those states and the District of Columbia, Massachusetts uses a spend down period that is longer than one month,[6] specifically, a six-month period for determining an applicant's excess income. See Mass. Ann. Laws ch. 118E, § 10 (Law. Co-op. 1975); see also 106 C.M.R. 506.510. When the applicant's medical expenses are greater than this six-month total of excess income, he or she qualifies for Medicaid for the remainder of the six-month period.[7]

To illustrate: if an applicant has a monthly income of $400 and the Medicaid eligibility standard is $300 per month, his income for the six-month spend down period would be $2,400 (6 x $400) and the Medicaid standard for the period would be $1,800

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[6] See S.J.C. App. 168 ("S.J.C. App." refers to the joint appendix filed in the Supreme Judicial Court). The Secretary has advised us of several changes that have occurred since the chart appearing at S.J.C. App. 168 was prepared. Thus, five states (Texas, South Carolina, Georgia, Iowa, and Oregon) now offer Medicaid to the medically needy and use a multi-month spend down period. In addition, the period is now one month in Illinois and as long as six months in Oklahoma.

[7] To qualify, an individual need not actually spend the money on medical expenses but must only "incur" them during the six-month period. See 42 U.S.C. 1396a(a)(17), 1396b(f)(2). However, the individual cannot anticipate future medical expenses he believes may be incurred during the six-month period. See *Hogan* v. *Heckler*, 769 F.2d at 897-898; *Williams* v. *St. Clair*, 610 F.2d 1244, 1248 (5th Cir. 1980). For individuals in long-term care facilities, the Secretary permits the anticipated costs of long-term care to be taken into account at the outset of the spend down period. See S.J.C. App. 6. This is because of the unique statutory and administrative requirements applicable to Medicaid recipients in long-term care facilities. See 42 U.S.C. 1396p(c)(2)(B)(i); 42 C.F.R. 435.725, 435.733, 435.832.

(6 x $300). Thus, the applicant would then have $600 ($2,400 minus $1,800) in excess income that must be "spent down" on medical care before he qualifies for Medicaid. Once the applicant incurs these expenses he is eligible for Medicaid for the remainder of the six-month period. At the end of the six-month period, the applicant must again meet the spend down limit before qualifying for Medicaid assistance in subsequent periods. The spend down therefore is roughly comparable, in an operational sense, to the deductible in an insurance policy: it is the amount the individual must spend before payments are provided for any covered services.

4. Respondent Rivera is the mother of two children. Because her income is too high she cannot qualify for AFDC and therefore is not automatically eligible for Medicaid as categorically needy. She also failed to qualify as a medically needy Medicaid recipient because she had not spent down her excess income on medical care. After benefits were denied and respondent had exhausted her administrative remedies, she brought this class action in Massachusetts Superior Court claiming, among other things, that she was illegally denied Medicaid benefits by the State. Specifically, respondent alleged that her monthly income exceeded the Medicaid eligibility standard by $100.30 and that under Massachusetts's six-month spend down she was required to spend $601.80 on medical care in order to qualify for Medicaid. J.A. 19. Respondent further alleged that she did not meet the six-month spend down amount, but that if the State were required to use a one-month spend down, she would have qualified for Medicaid as medically needy during the month of February 1983, when she incurred medical expenses of $314. *Ibid.* Respondent claimed that the State's six-month spend down violated 42 U.S.C. 1396a(a)(10)(C)(i)(III)

and 1396a(a)(17) because the "same methodology" was not used for computing the income of the medically and categorically needy. J.A. 21-22.[8]

On cross-motions for summary judgment, the superior court ruled for respondent. Pet. App. A28-A45. First, it held that class certification was appropriate. *Id.* at A34. Turning to the merits, the court held (*id.* at A40-A41) that the State's six-month spend down period violated the "same methodology" provision of 42 U.S.C. 1396a(a)(10)(C)(i)(III). The court noted that AFDC eligibility is statutorily required to be computed over a one-month period (42 U.S.C. 602(a)(13)) but that respondent Rivera and other AFDC-related medically needy applicants had their spend down amount for Medicaid eligibility computed over a six-month period. Pet. App. A41. To the court, this set up two different eligibility standards for the AFDC categorically needy and the AFDC-related medically needy, thereby conflicting with Section 1396a(a)(10)(C)(i)(III). Pet. App. A41-A42.

The superior court rejected (Pet. App. A43) the State's argument that its six-month spend down was authorized by the Secretary's regulation (42 C.F.R. 435.831). The court found that the regulation had been supplanted by federal legislation in 1981 that mandated for the first time a one-month budget period for AFDC. Thus, the court concluded that the Secretary's regulation "would not control." Pet. App. A43.

5. The Supreme Judicial Court of Massachusetts affirmed. Pet. App. A1-A26. The court rejected the

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[8] Respondent also claimed (J.A. 20) that the State's method of computing gross income violated state law. The state superior court agreed with respondent (Pet. App. A38) but the Supreme Judicial Court reversed. *Id.* at A10-A22. That issue is not raised in this Court.

State's claim that because there is no spend down computation for determining AFDC eligibility, computing the spend down amount for the medically needy could not be governed by the "same [AFDC] methodology." *Id.* at A23. While acknowledging (*id.* at A25) that "eligibility determinations for the categorically needy do not involve spend downs * * *," the court deemed this difference to be of no significance because it regarded the time period used to compute the spend down amount as the equivalent of the budget period used to compute AFDC eligibility. *Ibid.* The court further concluded that the use of a six-month spend down period conflicted with a congressional desire "to prevent the States from pursuing * * * more restrictive treatment of the medically needy" than the categorically needy. *Id.* at A26.

SUMMARY OF ARGUMENT

1. Since the inception of the Medicaid program, a regulation issued by the Secretary of Health and Human Services has authorized Massachusetts, and other participating states, to grant Medicaid benefits to an applicant whose income exceeds the eligibility standard, when, over a six-month period, the applicant's "excess income" is "spent down" to the designated level. This regulation has been upheld as a reasonable interpretation of the Medicaid Act by the two federal courts of appeals that have considered the question. *Hogan* v. *Heckler*, 769 F.2d 886 (1st Cir. 1985); *DeJesus* v. *Perales*, 770 F.2d 316 (2d Cir. 1985). As these courts have recognized, there is no basis in either the language or legislative history of the Medicaid Act for invalidating the Secretary's longstanding regulation. The plain language of the statute expressly grants broad authority to the Secretary to "prescribe[]" rules on how to take the costs of medical care into account in determining

Medicaid eligibility. See 42 U.S.C. 1396a(a)(17). In addition, the legislative history confirms that the Secretary is to have broad discretion in implementing this intricate statute. As this Court has repeatedly confirmed, when the Secretary adopts a rule pursuant to an express grant of authority, that rule is " 'entitled to more than mere deference or weight * * *.' Rather, the Secretary's [rule] is entitled to 'legislative effect * * *.' " *Schweiker* v. *Gray Panthers*, 453 U.S. 34, 44 (1981), quoting *Batterton* v. *Francis*, 432 U.S. 416, 425-426 (1977).

The Secretary's spend down regulation is particularly compelling because it was adopted at the inception of the Medicaid program. On at least three subsequent occasions Congress has amended the statutory provisions dealing with the eligibility standards of the medically needy and has not disapproved of the Secretary's policy. Indeed, Congress expressly ratified the Secretary's spend down regulation in the legislative history of the 1982 amendments to the Act. Clearly, there is no basis for setting aside this longstanding administrative interpretation.

Finally, the Secretary's authorization of a six-month spend down period makes fiscal sense and is faithful to the Act's policy of focusing the "limited resources * * * [for] welfare" (*Gray Panthers*, 453 U.S. at 48) on those " 'people [who] are the most needy * * *.' " *Schweiker* v. *Hogan*, 457 U.S. 569, 590 (1982), quoting H.R. Rep. 213, *supra*, at 66. High medical costs that reduce a claimant's income to Medicaid eligibility levels over a six-month period are far more persuasive indicia of hardship than are the medical costs incurred in any one-month period, which may be idiosyncratic and not present a true picture of a claimant's financial condition. The Secretary's regulation permits the states to focus their scarce resources on the former group, who obviously

have the greater need for assistance. Furthermore, use of a six-month spend down eases the administrative burden placed on the states. It requires that they compute Medicaid eligibility on a semi-annual rather than a monthly basis, thus allowing limited state funds to be spent on medical care rather than on the administration of this massive program.

2. The decision below turns in large part on a misinterpretation of the term "same methodology" in 42 U.S.C. 1396a(a)(10)(C)(i)(III). Because the AFDC program, by definition, contains no spend down mechanism, there is no AFDC "methodology" to apply to the spend down period. Moreover, the legislative history explaining the term "methodology" undermines the state court's construction and supports the Secretary's reading of the statute. That history shows that the statutory reference to "methodology" has nothing to do with the computation of the spend down amount.

3. Nor can the decision below be justified by the "comparability" requirement of 42 U.S.C. 1396a(a)(17). That requirement is irrelevant to the spend down computation, since it appears in the very same section of the statute in which Congress conferred broad authority upon the Secretary to determine how the spend down computation should be performed. It is this specific grant of authority, and not the general "comparability" language, that governs here.

In sum, the state court was not free to set aside the Secretary's regulation simply because it preferred another interpretation of this complex statutory scheme. The language of the Act, the legislative history, and the administrative practice compel the conclusion that Congress did not mandate a one-month spend down period. In these circumstances, the Secretary's reasonable and longstanding regulation must be upheld.

ARGUMENT

THE SECRETARY'S REGULATION AUTHORIZING UP TO A SIX-MONTH PERIOD FOR COMPUTING EXCESS INCOME THAT MUST BE SPENT DOWN TO QUALIFY FOR MEDICAID IS CONSISTENT WITH THE LANGUAGE AND POLICIES OF THE MEDICAID ACT AND IS CLEARLY WITHIN THE SCOPE OF THE SECRETARY'S RULEMAKING AUTHORITY

A. The Secretary's Longstanding Regulation Adopted Pursuant To An Express Grant Of Rulemaking Authority Must Be Given Controlling Weight

1. "The Social Security Act is among the most intricate ever drafted by Congress. * * * Perhaps appreciating the complexity of what it had wrought, Congress conferred on the Secretary [of Health and Human Services] exceptionally broad authority to prescribe standards for applying certain sections of the Act." *Schweiker* v. *Gray Panthers*, 453 U.S. 34, 43 (1981). Among those sections is the statutory provision that allows an applicant to qualify for Medicaid by spending down excess income on medical care. 42 U.S.C. 1396a(a)(17) (emphasis added) provides in pertinent part:

> A State plan for medical assistance must * * * include reasonable standards * * * for determining eligibility for and the extent of medical assistance under the plan * * * and provide for flexibility in the application of such standards with respect to income *by taking into account, except to the extent prescribed by the Secretary, the costs * * * incurred for medical care* or for any other type of remedial care recognized under State law * * *.

The statute gives the Secretary broad authority to "prescribe[]" how the costs of medical care should be considered; it does not require the Secretary to compute spend down amounts over any particular

period. See *Hogan* v. *Heckler*, 769 F.2d 886, 896-897 (1st Cir. 1985). Nor does the statute place participating states into an administrative or regulatory straitjacket in considering medical expenses. On the contrary, it expressly allows participating states to "provide for flexibility" in taking into account the costs of medical care. The Secretary's regulation, which permits states to choose a period of up to six months to compute this amount,[9] is faithful to the statute's expressly stated emphasis on "flexibility." See *DeJesus* v. *Perales*, 770 F.2d 316, 324 (2d Cir. 1985); *Williams* v. *St. Clair*, 610 F.2d 1244, 1248 (5th Cir. 1980).[10]

The Secretary's regulation thus is supported by the plain language of the statute. As a regulation adopted pursuant to the explicit grant of rulemaking authority in Section 1396a(a)(17), it is " 'entitled to more than mere deference or weight.' " *Gray Panthers*, 453 U.S. at 44, quoting *Batterton* v. *Francis*, 432 U.S. at 426. It must be given "legislative effect" (432 U.S. at 425) and is entitled to "controlling weight" (*Chevron U.S.A. Inc.* v. *Natural Re-*

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[9] The regulation (42 C.F.R. 435.831) provides:

> The [state Medicaid] agency must determine income eligibility of medically needy individuals in accordance with this section. The agency must use a prospective period of not more than 6 months to compute income.

[10] In addition to the authority conferred on the Secretary by Section 1396a(a)(17), the Act also gives the Secretary the power to "make and publish such rules and regulations, not inconsistent with [the Act], as may be necessary [for its] efficient administration." 42 U.S.C. 1302. Since the Act does not specify any length of time for computing the spend down amount (see *Hogan* v. *Heckler*, 769 F.2d at 889), even in the absence of Section 1396a(a)(17) the general rulemaking authority in Section 1302 would be sufficient authorization for the Secretary to fill in the gaps left by Congress.

sources Defense Council, Inc., No. 82-1005 (June 25, 1984), slip op. 5), unless it is arbitrary, capricious or inconsistent with the Medicaid statute.

2. a. The Secretary's regulation authorizing up to a six-month spend down period is also supported by the legislative history of Section 1396a(a)(17). See *Hogan* v. *Heckler*, 769 F.2d at 892-893. The spend down provision was "designed to correct one of the weaknesses identified in the medical assistance for the aged program." S. Rep. 404, *supra*, at 78. Specifically, Congress focused on the problem of a person "whose income exceeds the [income] limitation adopted by the State" and thus is "ineligible for * * * medical assitance," but whose expenditures for medical care on occasion may reduce his disposable income to a point near the level needed for categorical assistance. *Ibid.* Congress's solution was to direct the Secretary and participating states to "take into account, except to the extent prescribed by the Secretary, the costs * * * incurred for medical care." *Ibid.* Like the language of the statute, which the Senate Report tracks, the Report shows that Congress conferred broad discretion on states and the Secretary in taking into account the costs of medical care in determining the Medicaid eligibility of the medically needy. See *Hogan* v. *Heckler*, 769 F.2d at 893. The House Report contains virtually identical language. See H.R. Rep. 213, *supra*, at 68.

Nothing in the legislative history indicates that Congress intended to mandate any particular spend down period, much less a one-month period. Indeed, to the extent Congress expressed any view on the length of the spend down period, it directly contradicted the state court's conclusion that a one-month period is required. The House Report, in describing the effect of the spend down amount, used a *one-year* period to illustrate the operation of the spend down

concept. See H.R. Rep. 213, *supra*, at 68 (emphasis added) ("If the test of eligibility should be *$2,000 a year*, an individual with income in excess of that amount shall not be required to use his income [on medical care] to the extent he has remaining less than $2,000."). In light of this reference to a possible *annual* spend down computation, there is no basis upon which to conclude that the Secretary's authorization of a six-month period conflicts with the Act. See *Hogan* v. *Heckler*, 769 F.2d at 893.

b. It also is significant that the Secretary's decision to authorize a spend down period of up to six months was included in the first set of Medicaid instructions issued by the Department of Health, Education, and Welfare (*Handbook of Public Assistance Administration—Supplement D* § D-4220(A)(4) (June 17, 1966)); and it was included in the first set of Medicaid regulations adopted in 1969. 34 Fed. Reg. 1321 (codified at 45 C.F.R. 248.21(a)(4) (1970)). See *DeJesus* v. *Perales*, 770 F.2d at 322-323 n.8; *Hogan* v. *Heckler*, 769 F.2d at 893 nn.13, 14. Thus, the administrative determination was made immediately after the Act's passage "by the men charged with the responsibility of setting its machinery in motion, of making the parts work efficiently and smoothly while they are yet untried and new." *Norwegian Nitrogen Products Co.* v. *United States*, 288 U.S. 294, 315 (1933); see *Andrus* v. *Shell Oil Co.*, 446 U.S. 657, 667-668 (1980).

These principles are particularly appropriate where, as here, Congress has forgone opportunities to alter the Secretary's view. On no less than three occasions since the agency adopted its spend down policy in 1966, Congress has amended the provisions of the Medicaid Act dealing with eligibility standards for the medically needy; not once has it disapproved of

the Secretary's policy.[11] In fact, as we discuss below (pages 22-23), in considering one of the most recent amendments to the Act, Congress expressly approved of the regulation at issue here. See H.R. Rep. 97-757, 97th Cong., 2d Sess. Pt. 1, at 13 (1982). In such circumstances, where Congress is aware of the Secretary's construction and has seen fit not to overturn it, the courts are bound to conclude that the agency has correctly discerned the legislative intent. See *United States* v. *Rutherford*, 442 U.S. 544, 554 (1979). See also *EEOC* v. *Associated Dry Goods Corp.*, 449 U.S. 590, 600 n.17 (1981); *Board of Governors* v. *First Lincolnwood Corp.*, 439 U.S. 234, 248, 251 (1978); *Apex Hosiery Co.* v. *Leader*, 310 U.S. 469, 489 (1940).

3. Finally, the Secretary's regulation, and the State's decision to use a six-month spend down period, are fully consistent with the policies underlying the Medicaid program. As noted above, states are not obliged to offer Medicaid to the medically needy; the decision whether to participate in the program is left to the discretion of each state. See *Schweiker* v. *Hogan*, 457 U.S. at 573. Congress made this coverage optional so that the "most needy" would "have the first call upon the resources of the States to provide medical care." H.R. Rep. 213, *supra*, at 66.

Massachusetts's six-month spend down period is faithful to this policy because it allows the State to focus its resources on those most in need of assistance. See *Hogan* v. *Heckler*, 769 F.2d at 889; cf. *Schweiker* v. *Hogan*, 457 U.S. at 590. Unquestionably, a person whose medical expenses for one month may bring him below the Medicaid eligibility limit is not as needy

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[11] See Pub. L. No. 93-233, § 13(a)(3), 87 Stat. 960; Pub. L. No. 97-35, § 2171(a), 95 Stat. 807; Pub. L. No. 97-248, § 137(b)(8), 96 Stat. 378.

as someone who incurs more substantial medical expenses for six months. As the Second Circuit noted, "[u]sing a one-month spend-down * * * would mean that individuals with relatively high monthly incomes might qualify for Medicaid coverage of a substantial part of a larger hospital bill received in a single month, even though such individuals would have excess income in subsequent months that could be used to help pay the bill." *DeJesus* v. *Perales*, 770 F.2d at 322; see *Hogan* v. *Heckler*, 769 F.2d at 990 n.10. Massachusetts, like many other participating states, has chosen not to extend its Medicaid program to such individuals, and by limiting benefits to those most needy, is able to offer a wider range of medical services and a more generous standard of income eligibility. 42 U.S.C. 1396, 1396a(a)(10)(C)(i)(II) and (C)(iv); 42 C.F.R. 440.220.

The lower court's reasoning, however, would require Massachusetts, and some 28 other states and the District of Columbia, to expand their Medicaid programs dramatically to include persons who might have high medical costs for only a single month. Indeed, Massachusetts estimates that in the first year alone the change to a one-month spend down period would cost an additional $20 million, or more than 40% of the State's total expenditures for the AFDC-related medically needy. See S.J.C. App. 186.[12] This change would force a significant reallocation of the resources of the State and might lead to a reduction in the benefits presently offered to those persons considered the most needy. When faced with the prospect of such increased costs, some states might seek to keep expenses constant by eliminating coverage for

[12] Similarly, in *DeJesus* v. *Perales*, 770 F.2d at 320, it was estimated that New York would incur annual additional expenditures of $78 million.

certain services or by making eligibility standards more restrictive. Other states might even reconsider their decision to offer any optional Medicaid assistance to the medically needy. These results cannot be squared with the policies underlying the Medicaid Act. See *Hogan* v. *Heckler*, 769 F.2d at 899.

In this complex area of social policy, any effort to draw lines among the needy is difficult and subject to criticism. Wherever the line is drawn, those who narrowly fail to qualify are nonetheless needy. Cf. *Schweiker* v. *Hogan*, 457 U.S. at 589-592. That is true whether the spend down period is six months or one month. For example, at respondent Rivera's income level, a one-month spend down would be $100.30. In other words, if she incurred $300 in medical expenses in a particular month,[13] a one-month period would make $199.70 of that total eligible for coverage and would reduce her out-of-pocket cost to $100.30. Suppose, however, that another individual at the same income level had recurring monthly medical expenses of $100. That individual would never become eligible for Medicaid, yet at the end of six months he would be out of pocket $600. Although over six months he would have incurred medical expenses twice that of respondent Rivera's ($600 versus $300), he would receive no Medicaid benefits while she would. As a result, his out-of-pocket costs would be almost six times higher than respondent's ($600 versus $100.30). As this example shows, the decision below does not eliminate harsh consequences, it simply shifts the place where the line is drawn. But that is a decision properly left to the expert agency to which Congress has delegated that responsibility.

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[13] Respondent Rivera alleged that her medical expenses in February 1983 were $314 (J.A. 19).

In addition, the Secretary's regulation significantly eases the administrative burden on those states offering Medicaid to the medically needy, a policy expressly recognized by the Act. See 42 U.S.C. 1302. Since states must recompute Medicaid eligibility at the end of each spend down period, the six-month period "limit[s] the frequency of redetermination of eligibility for the medically needy." *Doe* v. *Wilson*, [1982] Medicare and Medicaid Guide (CCH) ¶ 32,148, at 10,544 (D. Vt. Aug. 16, 1982). The added costs involved in making these more frequent computations would increase state spending not on the medically needy, but on hiring more employees to deal with the dramatically expanded case load. See S.J.C. App. 183-186. Faced with the reality that "[t]here are limited resources to spend on welfare" (*Gray Panthers*, 453 U.S. at 33), the Secretary's decision to ease the administrative burden on participating states and thereby not "dissipate resources that could have been spent on the needy" (*ibid.*) is surely a reasonable one.

B. The Secretary's Regulation Is Consistent With The "Same Methodology" Language Of The Act Since That Language Does Not Refer To The Length Of The Spend Down Period

In holding that the Medicaid Act mandates a one-month spend down period, the court below relied heavily on 42 U.S.C. 1396a(a)(10)(C)(i)(III). In pertinent part, that provision states (emphasis added):

> [T]he methodology to be employed in determining [medically needy] eligibility * * * shall be the *same methodology* which would be employed under the supplemental security income program in the case of groups consisting of aged, blind, or disabled individuals in a State in which such program is in effect, and which shall be the same methodology which would be employed under the appropriate State plan * * *

> to which such group is most closely categorically related in the case of other groups * * *.

The court reasoned that the phrase "same methodology" must include the length of time used to compute the spend down amount. Since the budget period for AFDC is one month (see 42 U.S.C. 602(a)(13)), the court concluded that it must be one month for the Medicaid spend down period as well. As both the First and Second Circuits have held, this conclusion is based on an erroneous understanding of the word "methodology." *DeJesus* v. *Perales*, 770 F.2d at 324-326; *Hogan* v. *Heckler*, 769 F.2d at 899-901. Neither the language of the statute nor the legislative history supports the state court's analysis. Indeed, as we now show, there are clear indications that Congress endorsed the Secretary's interpretation.

1. The statutory language provides no support for the state court's conclusion that "methodology" must include the length of the spend down period. The Medicaid Act provides no definition of the term "methodology," much less one that embraces the state court's construction. Accordingly, it is the Secretary's interpretation to which the Court must look for guidance. See *Connecticut Department of Income Maintenance* v. *Heckler*, No. 83-2136 (May 20, 1985), slip op. 6. In the Secretary's view, the "same methodology" requirement refers only to those computations common to determining AFDC eligibility and Medicaid eligibility—*i.e.*, what income or resources are includable, how particular types of income (such as interest or court-ordered support) are treated, and what deductions or disregards to income are available. See 42 C.F.R. 435.831(a)(1)-(3). The spend down concept is not common to both programs. Since AFDC eligibility is categorical, there is no spend down computation. Thus, the spend down computation, a step unique to the Medicaid program,

cannot be governed by AFDC "methodology" because no such "methodology" exists. In these circumstances, the Secretary's reading of language left undefined by Congress is patently reasonable. See *DeJesus* v. *Perales*, 770 F.2d at 326.

Rather than look to the Secretary's expertise for guidance, the state court instead substituted its preferred reading of a highly technical statute. In doing so, the court misconceived its role. Where, as here, the agency is entrusted with interpreting the statute, the issue for the court is not whether the agency's construction is the only reasonable one or whether the court agrees with that construction. See *Connecticut Department of Income Maintenance* v. *Heckler*, slip op. 6. Rather, the question is whether "it is *a* reasonable interpretation of the relevant provisions." *American Paper Institute, Inc.* v. *American Electric Power Corp.*, 461 U.S. 402, 423 (1983) (emphasis in original). See *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, slip op. 5-6. Here, the legislative history plainly shows that the Secretary's interpretation of the term "methodology" is reasonable; in fact, it is the only plausible interpretation.

2. The "same methodology" requirement was enacted as part of the technical corrections to the Medicaid Act made by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Pub. L. No. 97-248, § 137(b)(8), 96 Stat. 378. This legislation was passed in response to regulations promulgated by the Secretary pursuant to a 1981 amendment to the Medicaid Act made in the Omnibus Budget Reconciliation Act of 1981 (OBRA). Pub. L. No. 97-35, § 2171(a)(3), 95 Stat. 807. The Secretary read OBRA's amendment of 42 U.S.C. 1396a(a)(10)(C)(i) as permitting the states to use income and resource standards and criteria for the medically

needy that differed from those used for the categorically needy. Consistent with that interpretation of the 1981 amendment, the Secretary issued regulations authorizing states to adopt different standards for computing income and available resources—steps common to AFDC eligibility and to Medicaid eligibility for the medically needy. These regulations had nothing whatever to do with the spend down computation. (The regulation governing the spend down was unchanged by these 1981 regulations.) See *Medicaid Program; Medicaid Eligibility and Coverage Criteria*, 46 Fed. Reg. 47976 (1981).

The next year, in TEFRA, Congress amended Section 1396a(a)(10)(C)(i) to include the "same methodology" requirement, specifying that its sole intent was to disapprove of the Secretary's 1981 regulations. The House Report explaining the "same methodology" requirement clearly demonstrates that the spend down regulation was not one of Congress's concerns. H.R. Rep. 97-757, 97th Cong., 2d Sess. Pt. 1, at 13 (1982) (emphasis added):

> [T]he 1981 Reconciliation Act made no changes in the applicable income and resource eligibility rules.
>
> Unfortunately, the Department, in its interim final rule of September 30, 1981, 46 Fed. Reg. 47976, assumed that the conferees had intended to give the States extensive flexibility in this area as well. This is simply incorrect. When the Statement of Managers of the conference committee report spoke of providing the States "with flexibility in establishing eligibility criteria and scope of services within the medically needy program to address the needs of different population groups more appropriately," (H.R. Rep. 97-208, p. 971), it was referring to the service package and coverage group provisions, not inviting a wholesale rewriting of current income

> and resource standards and methodologies. This amendment makes clear that the Department had no authority to alter the rules that applied before September 30, 1981, with respect to medically needy income levels, medically needy resource standards, and the methodology for treating medically needy income and resources. *The Committee bill reaffirms the financial requirements previously in effect for the medically needy (42 C.F.R. sec. 435.800-435.845).*

The language in the House Report is critical in two respects. First, in emphasizing that the "same methodology" requirement was intended to overrule only the 1981 regulations dealing with matters other than spend down, the Report made clear that the spend down period was in no way affected by the amendment. See *DeJesus* v. *Perales*, 770 F.2d at 727; *Hogan* v. *Heckler*, 769 F.2d at 901. Second, the Report expressly approved the pre-1981 OBRA regulations, which contained the regulation authorizing a six-month spend down (42 C.F.R. 435.831). As the First Circuit noted in *Hogan* v. *Heckler*, 769 F.2d at 901 (emphasis in original): "*the quoted Report specifically 'affirm[ed] the financial requirements' previously contained in 42 C.F.R. §§ 435.800-435.845. This included the regulation challenged in this action allowing a six month spenddown period, 42 C.F.R. § 435.831.* * * * It is hard to imagine a clearer indication that Congress *did not* intend to equate the length of the spenddown period with the length of the budget period used to determine income."

That Congress did not intend to abrogate the spend down regulation is obvious from an examination of the 1981 regulations to which the "same methodology" language was directed. The preamble to the 1981 regulations discussed the concept of methodology, and conclusively establishes that the spend down

period was not included (46 Fed. Reg. 47980 (1981) (emphasis added)):

> G. *Treatment of Income and Resources*
>
> 1. *Provisions:* States are no longer required to apply a uniform methodology for treating income and resources in such matters as *deemed income, interest, court-ordered support payments, and infrequent and irregular income.* Rather the State plan must specify the methodology that will be used; and that methodology must be reasonable. (See 42 C.F.R. 435.850-435.852 and 436.850-436.852, as added by this final rule.)
>
> 2. *Discussion:* Before the 1981 Amendments, the methodology *for treatment of income and resources* of the medically needy depended on the individuals' relationship to a specific cash assistance program. For example, the methodology for deeming the income of medically needy aged, blind, and disabled was taken from the SSI program. This was based on the former wording of section 1902(a)(10) of the Act that described the medically needy, in part, as individuals who "except for income and resources" would be eligible for cash assistance and for Medicaid as categorically needy. Furthermore, section 1902(a)(17)(C) of the Act required that the methodology for the treatment of income and resources be reasonable and gave the Secretary authority to prescribe standards regarding that methodology.

Thus, the term "methodology," as used in the preamble to the 1981 regulations, referred solely to the general treatment of income and resources; it did not include the length of the spend down period. Nor was 42 C.F.R. 435.831 (which authorizes the use of a six-month spend down period) identified as a regulation

relevant to the change in permissible "methodology." Since the 1982 TEFRA amendment adding the "same methodology" language sought to undo only the changes made by the 1981 regulations, and those regulations clearly did not affect the spend down period, the reference to "methodology" in 42 U.S.C. 1396a(a)(10)(C)(i)(III) cannot sensibly be read to include spend down. See *DeJesus* v. *Perales*, 770 F.2d at 327; *Hogan* v. *Heckler*, 769 F.2d at 901.[14] Accordingly, the state court's conclusion that the 1982 amendment to the Act disapproved of HHS's regulation authorizing up to a six-month spend down period must be rejected.[15]

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[14] Subsequent legislative history further buttresses the Secretary's reading of the "same methodology" language. See *DeJesus* v. *Perales*, 770 F.2d at 326 n.12. In the Deficit Reduction Act of 1984, Congress amended Section 1396a(a)(10)(C)(i)(III) to impose a moratorium on the Secretary's disapproval of state Medicaid plans that might be inconsistent with the "same methodology" language of Section 1396a(a)(10)(C)(i)(III). See Deficit Reduction Act of 1984, Pub. L. No. 98-369, § 2373(c), 98 Stat. 1112. In enacting this moratorium, Congress reaffirmed that its sole intent in using the term "same methodology" was to override the Secretary's 1981 OBRA regulations. See H.R. Rep. 98-861, 98th Cong., 2d Sess. 1366-1367 (1982).

[15] The state superior court (Pet. App. A43) attributed significance to a provision in the 1981 OBRA that mandated one-month budgeting to calculate AFDC benefits. See Pub. L. No. 97-35, § 2315(a), 95 Stat. 855 (codified at 42 U.S.C. 602(a)(13)(A)). According to the state court, this represented an implicit repeal of the Secretary's longstanding regulation and implicitly required that the spend down amount be computed over a one-month period. The court's analysis is flawed in several respects. First, the legislative history of the change makes clear that it was aimed solely at correcting problems in the AFDC program. See S. Rep. 97-139, 97th Cong., 1st Sess. 516-517 (1981). Nothing in this amendment to the AFDC statute or its legislative history even hints at an intent

C. The Secretary's Regulation Is Consistent With The "Comparability" Requirement Of The Act

In the courts below, respondents also claimed that the Secretary's six-month spend down regulation conflicted with the "comparability" requirement of 42 U.S.C. 1396a(a)(17). Although the Supreme Judicial Court did not address that issue, respondents (Br. in Opp. 8 & n.4) rely on it as a basis for defending the judgment below.[16]

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to alter the Secretary's regulation authorizing a six-month spend down period under the Medicaid Act. The state court's reliance on this AFDC amendment therefore is flatly inconsistent with the settled rule that repeals by implication are disfavored. *Parsons Steel, Inc.* v. *First Alabama Bank*, No. 84-1616 (Jan. 27, 1986), slip op. 5; *Morton* v. *Mancari*, 417 U.S. 535 (1974). Second, as the First Circuit noted in *Hogan* v. *Heckler*, 769 F.2d at 901-902, although OBRA amended the AFDC statute to mandate one-month budgeting for calculating benefits, the 1982 House Report on TEFRA states that in OBRA Congress "expressly approved of [the Secretary's] regulations, including [the spend down regulation]." This explicit endorsement of the Secretary's spend down regulation surely nullifies any contrary inferences to be drawn from the AFDC amendment. Finally, although it was not until 1981 that Congress required a one-month budgeting period for calculating AFDC benefits, many states had previously used a one-month budget (see S. Rep. 97-139, *supra*, at 516), and the pre-existing AFDC statute had required states to determine AFDC eligibility (as opposed to the level of AFDC benefits) on a monthly basis. See 42 U.S.C. (1976 ed.) 602(a)(8) and (28); S. Rep. 97-139, *supra*, at 440. Thus, "throughout the period during which the Secretary's regulation permitting a six-month spend-down has been in force, eligibility for AFDC has been determined by calculating income on a monthly basis." *DeJesus* v. *Perales*, 770 F.2d at 323 n.9.

[16] Respondents also contend (Br. in Opp. 7-8) that another of the Secretary's regulations, 42 C.F.R. 435.401(c), bars the use of a six-month spend down period. That contention has no merit. Section 435.401(c) prevents a state's eligibility requirements for the medically needy from being more restric-

Section 1396a(a)(17) (emphasis added) provides in pertinent part:

> A State plan for medical assistance must * * * include reasonable standards (which shall be *comparable for all groups* and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of [the medically needy], based on the variations between shelter costs in urban areas and rural areas) for determining eligibility for and the extent of medical assistance under the plan * * *.

Respondents alleged in the state courts (J.A. 21-22) that since the AFDC program uses a one-month budget period, Section 1396a(a)(17) requires that a "comparable" period be used for the Medicaid spend down period. The First and Second Circuits correctly rejected this spurious contention. See *DeJesus* v. *Perales*, 770 F.2d at 323-324, 327; *Hogan* v. *Heckler*, 769 F.2d at 891-898.[17]

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tive than those used for the related categorically needy. The Secretary has consistently interpreted that regulation to apply solely to those determinations common to calculating eligibility for categorical assistance and Medicaid. Because AFDC eligibility involves no spend down calculation, it is impossible for the Medicaid spend down to be "more restrictive" than the nonexistent AFDC measure. The Secretary's interpretation of his regulations is thus clearly reasonable and is due the greatest deference. *Ford Motor Credit Co.* v. *Milhollin*, 444 U.S. 555 (1980).

[17] Cases that have read Section 1396a(a)(17) or Section 1396a(a)(10) to require comparability between the medically needy and categorically needy are readily distinguishable. Most important, none of those cases dealt with the spend down period. Instead, they all concerned income and resource computations for determining the Medicaid eligibility of the medically needy—computations that are common to determining eligibility for AFDC. See *Beltran* v. *Myers*, 701 F.2d 91

First, the statute's "comparability" requirement is not relevant to determining the spend down amount. The "comparability" requirement of Section 1396a (a)(17) was a feature of the original Medicaid Act; for nearly two decades, however, the Secretary has interpreted that requirement not to preclude states

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(9th Cir.), cert. denied, 462 U.S. 1134 (1983) (transfer of assets rule); *Caldwell* v. *Blum*, 621 F.2d 491 (2d Cir. 1980), cert. denied, 452 U.S. 909 (1981) (same); *Fabula* v. *Buck*, 598 F.2d 869 (4th Cir. 1979) (same); *Greklek* v. *Toia*, 565 F.2d 1259 (2d Cir. 1977), cert. denied, 436 U.S. 962 (1978) (work expenses deductions from income); *Calkins* v. *Blum*, 511 F. Supp. 1073 (N.D.N.Y. 1981), aff'd, 675 F.2d 44 (2d Cir. 1982) (income disregard rule). Thus, they did not concern the problem presented here—a computation unique to determining the Medicaid eligibility of the medically needy. See *DeJesus* v. *Perales*, 770 F.2d at 328.

These cases differ from this one in another significant respect. In striking down the state Medicaid rules at issue, the courts relied heavily on the fact that the state rules conflicted with the Secretary's regulations that mandated identical treatment for the particular computation. See *Caldwell*, 621 F.2d at 495; *Greklek*, 565 F.2d at 1261 n.5; *Calkins*, 511 F. Supp. at 1093. Here, by contrast, the state's Medicaid rule is affirmatively authorized by the Secretary's longstanding regulation. See *Hogan* v. *Heckler*, 769 F.2d at 898.

Respondents also claim (Br. in Opp. 8) that Massachusetts violates the comparability requirement by treating some AFDC-related medically needy differently from others. In particular, respondents state that in Massachusetts some AFDC-related medically needy qualify for Medicaid without a spend down because Massachusetts uses a Medicaid income eligibility standard that is slightly higher than the AFDC standard (see note 4, *supra*). Respondents then assert that Massachusetts computes the income of this group over one month, but uses a six-month period for those AFDC-related medically needy not in this group. In fact, however, there is no disparity in treatment in computing the spend down amount among the AFDC-related medically needy, because there is no need to perform that computation for persons who already meet the Medicaid standard.

from using spend down periods as long as six months. Indeed, it would be anomalous to conclude that the "comparability" requirement implicitly governs the spend down period when the statute's express reference to the spend down concept, which is at the end of the same subsection, specifies only that state plans must "provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs * * * incurred for medical care." 42 U.S.C. 1396a(a)(17); see also 42 U.S.C. 1396b(f)(2).

Accordingly, Section 1396a(a)(17) gives broad discretion to the Secretary, and to participating states, to determine how to take the costs of medical care into account in determining Medicaid eligibility for the medically needy. This express delegation to the Secretary to determine how much an applicant for Medicaid must spend for medical care refutes respondents' argument that the vague "comparable standards" language reflects Congress's intent that the spend down amount be computed in a specific fashion. See *DeJesus* v. *Perales*, 770 F.2d at 324; *Hogan* v. *Heckler*, 769 F.2d at 893, 896-897.

Second, as this Court has recognized, although Section 1396a(a)(17) requires "comparability among the various 'categories' for which federal assistance [is] available, * * * th[is] provision[] d[oes] not require that the medically needy be treated comparably to the categorically needy in all respects." *Schweiker* v. *Hogan*, 457 U.S. at 587. Thus, it cannot be asserted that the Act mandates *identical* treatment for both the categorically needy and the medically needy in every aspect of determining Medicaid eligibility. If Congress had intended that there be no difference in treatment between the categorically needy and the medically needy, it surely would have

said so. But the statute says that treatment must be "comparable," not identical. As Judge Friendly wrote for the Second Circuit, "[c]omparison invites an examination of differences as well as resemblances." *DeJesus* v. *Perales*, 770 F.2d at 324. And the obvious difference between the categorically needy and the medically needy is that while the former automatically qualify for Medicaid, the latter have excess income that must be spent on medical care before they qualify. See 42 U.S.C. 1396a(a)(17); 42 C.F.R. 435.831(d). The categorically needy have no spend down amount, hence no spend down period. Comparability, therefore, can hardly require identical treatment on the point at issue in this case.

CONCLUSION

The judgment of the Supreme Judicial Court of Massachusetts should be reversed.

Respectfully submitted.

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FEBRUARY 1986

☆ U. S. GOVERNMENT PRINTING OFFICE: 1986 491507 20142

Supreme Court, U.S.
FILED
JAN 30 1986
JOSEPH F. SPANIOL, JR.
CLERK

No. 85-632

IN THE

Supreme Court of the United States

October Term, 1985

CHARLES ATKINS, Commissioner of the Massachusetts Department of Welfare,

Petitioner,

v.

SANTOS RIVERA, Madeline McKenna, and all others similarly situated,

Respondents.

ON A WRIT OF CERTIORARI TO THE SUPREME JUDICIAL COURT FOR THE COMMONWEALTH OF MASSACHUSETTS

Brief of the Attorney General of the State of New York *Amicus Curiae*

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Dated: January 30, 1986

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IN THE

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OCTOBER TERM, 1985.

CHARLES ATKINS, Commissioner of the Massachusetts Department of Welfare,

Petitioner,

v.

SANTOS RIVERA, MADELINE MCKENNA, and all other similarly situated,

Respondents.

ON A WRIT OF CERTIORARI TO THE SUPREME JUDICIAL COURT FOR THE COMMONWEALTH OF MASSACHUSETTS

Brief of the Attorney General of the State of New York *Amicus Curiae* Urging Reversal of the Order of the Massachusetts Supreme Judicial Court.

Interest of the State of New York.

New York State Department of Social Services regulations, authorized by 42 CFR §435.831, provide that, for in-hospital care, the patient's excess income for a period of six months shall be considered as available for payment in computing the amount which a person who claims to be medically needy is required to "spend down" (*i.e.*, incur) to reach New York Medicaid eligibility levels.[1] New York's spend down provision was sustained, as to the AFDC-related medically needy,[2] in *DeJesus v. Perales*, 770 F2d 316 (2d Cir, Friendly, J. [1985]).[3] The time within which plaintiff in *DeJesus* may file a petition for a writ of certiorari has been extended until February 17, 1986. It is apparent that the merits which will probably be dispositive of the application in *DeJesus* will be governed by the Court's decision here as to the Massachusetts six-month spend down provision.

New York's interest in reversal of the order here and in sustaining the judgment in *DeJesus* is substantial. The fiscal impact of an adverse judgment in *DeJesus* upon the existing New York case load (both AFDC and SSI) has been estimated by the New York State Department of

[1]For other medical care, New York uses a one-month spend down.

[2]The AFDC-related medically needy are those persons who reside with minor children and who would be eligible for Aid to Families with Dependent Children if they did not have income or resources in excess of State eligibility levels.

[3]The operation of the six-month spend down in New York is described at page 319 of the *DeJesus* opinion.

New York's spend down provision was sustained as to the SSI-related (those who are aged, blind or disabled and who would be eligible for Supplemental Security Income for the Aged, Blind or Disabled if they did not have income or resources in excess of eligibility levels) in *Cashman v. Perales*, ___F Supp___ (WDNY [1985]).

Social Services at $25 million to $30 million annually. $78 million in additional expenditures was estimated for those not presently receiving medical assistance who would become Medicaid-eligible if a one-month spend down were required. The United States, which supported New York's position in *DeJesus*, would be required to participate financially in the additional cost which a one-month spend down provision would impose upon Medicaid programs in New York and other states currently utilizing a spend down period of more than one month.

The complaint in *DeJesus* alleged that New York's six-month spend down requirement for inpatient hospital care violates the "same methodology" and "comparability" provisions of the Social Security Act, 42 USC §§ 1396a(a)(10)(C)(i)(III) and 1396a(a)(17), respectively. The opinion addressed both issues. The same attacks were made below in *Atkins*, but the decision in that case was grounded only upon the "same methodology" provision. Because a reply brief from *amici* is not permitted, we shall briefly address both aspects.[4] We believe that we can most usefully discharge our function as *amicus* by directing the Court's attention to the thorough and complete presentation of both issues as set out in *DeJesus*.

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[4]The *Atkins* Respondents are, of course, free to argue "comparability" in support of their judgment. *Schweiker v. Hogan*, 457 US 569, 585 (1982).

ARGUMENT.

Massachusetts and New York policy is firmly grounded on reasonable, valid federal regulations in 42 CFR §435.831 which authorize the use of a prospective period of not more than six months to compute income of the medically needy for medicaid eligibility.

The use of a six-month prospective spend down period to compute the income of the medically needy to determine Medicaid eligibility has been authorized in federal law for two decades. Its promulgation in the 1966 edition of the Secretary's "Handbook of Public Assistance Administration," its subsequent codification into the Code of Federal Regulations (now 42 CFR §435.831[5]) and its application for two decades were detailed by Judge Friendly in his opinion in *DeJesus* (770 F2d at 322, n 8). Writing for the *DeJesus* court, he cautioned against "allowing a literal reading of a relatively recent amendment to set at naught the experience of administrators acquired over a score of years." *Id.* at 321.

The thrust of the argument advanced by New York, supported by the Secretary of Health and Human Services and accepted by the court in *DeJesus*, was that Congress must have known that there cannot be identity in treatment between categorically needy persons eligible for AFDC and the AFDC-related medically needy. The Court of Appeals rightly stated that persons eligible for AFDC in a given month are by definition earning no more in that month than is required for the basic necessities of life excluding medical expenses. Because they are not required to

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[5]The regulation of the United States Secretary of Health and Human Services, 42 CFR §435.831, 42 USC §1396a(a)(10)(C)(i)(III) and 42 USC §1396a(a)(17) are reproduced *post*.

use funds required for basic necessities to pay for medical expenses, they are eligible for Medicaid (770F2d at 321).

The AFDC medically-related needy are different. Their monthly income is deemed more than sufficient to pay for the basic necessities of life. They can qualify for Medicaid, however, by "spending down" their excess income, a practice specifically authorized by 42 USC §1396a(a)(17). The Second Circuit stated that the dispute presented was whether a state in determining Medicaid eligibility for AFDC-related medically needy may calculate the spend down by taking into account a family's projected income over a six-month period, rather than over the one-month period that a state must use in determining whether a family is eligible for AFDC. 770 F2d at 322.[6]

The court recognized that New York has required a six-month spend down for coverage of inpatient hospital expenses in one form or another since the inception of its Medicaid program in 1966. After discussing the *rationale* underlying New York's policy, the court concluded that the regulations of the then Secretary of Health and Human Services (42 CFR §435.831) "plainly permit what New York has done" (770 F2d at 322) and also that those regulations were entitled to great deference. The Second

[6]The one-month provision was added to the AFDC statute in 1981 and is found in 42 USC §602(a)(13)(A). See Omnibus Budget Reconciliation Act, Public Law 97-35, §2315(a), 95 Stat 855. The Second Circuit rejected the argument that the "Secretary's long standing regulation * * * has been invalid since 1981 when Congress introduced one month budgeting in AFDC." 770 F2d at 322, n 9. Many states, it was found, used one month AFDC budgeting throughout the period that the Secretary's spend-down regulation has been in force. The *DeJesus* court found that the purpose of the 1981 amendment was to require *retrospective* one-month budgeting for AFDC to correct a high percentage of payment errors when prospective budgeting was done (*idem*).

Circuit noted that Title XIX of the Social Security Act "is shot through with references delegating the formulation of standards to the Secretary" (770 F2d at 327) and this Court's holdings in *Batterton v. Francis*, 432 US 416 (1977), and in *Schweiker v. Gray Panthers*, 453 US 34, 43 (1981), according them "legislative effect" (770 F2d at 327). Even when the Secretary has not been accorded such authority, it noted that "courts must exhibit particular deference to the Secretary's position with respect to legislation as intricate as Title XIX" (*id.*) In support of the latter proposition, the court in *DeJesus* cited *Connecticut Department of Income Maintenance v. Hecker*, ____ US ____, 105 S Ct 2210 (1985), a case having a remarkably similar factual pattern to *Atkins* and *DeJesus*, where this Court sustained a two-decade old construction of Title XIX by the Secretary, also first set out in his Handbook of Public Assistance in 1965. The issue before the *DeJesus* court then became whether there was anything in the long-existing "comparability" provision of 42 USC §1396a(a)(17) or in the "same methodology" provisions of section 1396a(a)(10)(C)(i)(III) added in 1982 which required a different result. The court first discussed "comparability." 770 F2d at 323.

The income standard comparability provision of 42 USC §1396a(a)(17) is irrelevant to the spend down computation.

The *DeJesus* court, which had decided most of the so-called comparability cases (see 770 F2d at 324, 328; *Schweiker v. Hogan*, 457 US at 588, n 28), held that it saw "little force in plaintiff's contention that New York's six-month spend down requirement violates" the statute. 770 F2d at 323. Noting that the "very purpose" of subdivision 17 "is to regulate the standards under which persons having incomes higher than allowed in the cash assistance pro-

gram may still qualify for Medicaid," it found that the statute could not be read to require that the standards must be the same as those in the cash assistance programs in all respects. Those standards, it held, are only required to be comparable, not identical, for all groups. Comparison, it noted, "invites an examination of differences as well as resemblances." It found further support for its position in this Court's opinion in *Schweiker v. Hogan*, 457 US at 587, which it read as holding that the comparability provisions of Title XIX, "including those in section 1396(a)(17) did not require that the medically needy be treated comparably to the categorically needy in all respects." 770 F2d at 324. Finally, it pointed out that subdivision 17 "invites 'flexibility' in applying income standards to the medically needy by taking into account their cost of medical care, except to the extent prescribed by the Secretary." Comparability and flexibility, both required by subdivision 17, it was stated, "do not mandate the rigidly identical treatment of categorically and medically needy Medicaid recipients for which plaintiff contends." 770 F2d at 324. *Accord Schweiker v. Hogan*, 457 at 577, n 28.

The *DeJesus* court has construed its comparability decisions and those of other courts, including this Court, correctly. The 1965 reports of both the United States Senate and the House of Representatives, written at the time of the enactment of Medicaid, dealt with what is involved in this case, *i.e.*, excess income. *See* S. Rep. No. 404, 89th Cong., 1st Sess. 79 (1965), Serial Set No. 12662-3, and H.R. Rep. No. 213, 89th Cong., 1st Sess. 68 (1965), Serial Set No. 12665-2. Only the medically needy have excess income. The categorically needy by definition do not. Excess income is determinable only *after* the budgeting process is completed. By the very nature of things, the relief sought

in *Atkins* and in *DeJesus* will not and cannot achieve an identical result as between the medically needy AFDC-related and the AFDC-categorically eligible. What plaintiff seeks in both cases is a one-month spend down, rather than a six-month spend down. Be it one month or six months, however, an AFDC-related medically needy person will be required to incur medical expenses equal to a spend down measured by "excess income." That requirement cannot be applicable to the AFDC-categorically eligible who receive Medicaid, without regard to their medical expenses, simply because they receive AFDC.

The spend down provisions of 42 USC §1396a(a)(17), set out in the same subdivision as the comparability provisions, do not contemplate identical treatment with respect to excess income for the medically needy and the AFDC categorically eligible because only the former have excess income. Those spend down provisions stand by themselves. Their application by Massachusetts and by New York should be sustained.

The "same methodology" language did not affect or change the six-month provision of 42 CFR §435.831.

The State court in *Atkins* has ignored the Secretary's construction of the Social Security Act, sustained in *DeJesus*,[7] by holding that the length of the spend down period is part of the methodology for evaluating income eligibility of the AFDC-related medically needy within the "same methodology" language of 42 USC §1396a(a)(10)

[7]This construction was sustained also as to the Massachusetts SSI-related medically needy in *Hogan v. Heckler*, 769 F2d 886 (1st Cir. 1985), *reversing* 597 F Supp 1106 (D. Mass. 1984), which had been relied upon by the *Atkins* court. The Secretary filed briefs in support of his regulation in both *DeJesus* (as *amicus curiae*) and in *Heckler* (as a party).

(C)(i)(III) (Petition, p A25). That provision, added by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (Public Law No. 97-48, §137[a][8]; 96 Stat 324, 378), requires a State, in determining income under the "single standard to be employed in determining income * * * eligibility," to use the "same methodology" as would be used for determining eligibility for the "most closely categorically related" groups. Here that group is those who are eligible for AFDC.

The *DeJesus* court has correctly found that the "same methodology" language did not affect or change the six-month provision of 42 CFR §435.831, and that such language does not apply to the spend down determination, an extra step unique to Medicaid. That court reviewed the pre-TEFRA provisions of then section 1396a(a)(10)(B) which, it stated, contained a requirement that a state's Medicaid plan use comparable criteria in calculating income and resources for the categorically and medically needy. It noted, however, that the section "imposed no requirement for how such plans should determine whether a medically needy person's income and resources were insufficient to meet medical costs." 770 F2d at 324-325.

The next changes in section 1396a(a)(10), preceding TEFRA, were effected by the Omnibus Budget Reconciliation Act of 1981 (OBRA) (Public Law No. 97-35; 95 Stat 357) which required only that a state's Medicaid plan for the medically needy include "a description of * * * the criteria for determining eligibility of individuals in the [medically needy] group for * * * medical assistance" (§1396a[a][10][C][i], §2171[a][3]; 95 Stat 807).[8] The court

[8]It is hardly disputable that OBRA and TEFRA were enacted by a cost-cutting Congress. There has been absolutely no showing, and we know of none, of an intent on the part of Congress to assume the massive additional expenditures which would be incurred if the states using a six-month spend down were reduced to a one-month spend

(Footnote continued on following page.)

then discussed the HHS position on the OBRA amendments as set out in its release published at 42 Fed Reg 47976, *et seq.*, in 1981, which allowed states to use income and resource criteria for the medically needy which were different from those applicable to the categorically needy. The regulations promulgated at that time, the court stated, "had nothing to do with the treatment of exess income for the medically needy or with the calculation of spend downs." 770 F2d at 325. The opinion quoted the Federal Register release verbatim and went on to note the "[c]ongressional displeasure with the Secretary's regulations" as expressed on the floor of the House of Representatives and in H.R. Report No. 757, Part 1, 97th Congress, 2d Sess 13 (1982). That report, set out at length in the court's opinion, 770 F2d at 325-326, took note of the Secretary's construction of OBRA as evincing an intent "to give the States extensive flexibility" as to the applicable income and resource eligibility rules, and said that such conclusion was incorrect. The report stated that the OBRA conferees had not "[invited] a wholesale rewriting of current income and resource standards and methodologies," and that the Department had no authority to alter the rules that applied before September 30, 1981 with respect to medically needy income levels, medically needy resource levels and the methodology for treating medically needy income and resources. The Committee concluded "[t]he committee Bill reaffirms the financial requirements previously in effect for the medically needy (42 C.F.R. Sec. 435.800-435.845)." Included, of course, was section 435.831, the Secretary's regulation involved in these cases.

(Footnote continued.)

down period. The United States, which participates financially with the states in the cost of medical assistance for the AFDC-related and the SSI-related (approximately 50% as to New York State), would incur large and unanticipated expenditures. Such was not the intent of the Congress in dealing with the medically needy in OBRA in 1981 or TEFRA in 1982.

The *DeJesus* court accepted the Secretary's position, also advanced by New York, that the legislative history makes clear that the "same methodology" language of TEFRA was intended to invalidate provisions of the Department's 1981 regulations which permitted the income and resource standards in state Medicaid plans to deviate from those used in AFDC and SSI programs, and that in enacting that language

> "Congress * * * did not at all intend to affect HHS's regulations dealing with treatment of excess income and the calculation of spend-downs—regulations which the Secretary had not altered following OBRA and which, in her view, the last sentence of the House Report * * * expressly reaffirmed." 770 F2d at 326.[9]

The *DeJesus* court stated that the spend down is not a part of the section 1396a(a)(10)(C)(i)(III) "standard to be employed in determining income and resource eligibility"; that such standard "so far as concerns income, is whether an applicant's monthly income after deduction of various expenses (other than medical expenses) and disregards is

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[9]Support for the Secretary's reading of the "same methodology" language was found by the court in the legislative history of the Deficit Reduction Act of 1984, Public Law No. 98-369, 98 Stat 494, at which time Congress imposed a moratorium on disapproval of state Medicaid plans that might be determined by the Secretary to be inconsistent with the "same methodology" provisions (§2372[c][1]; 98 Stat 1112). It was found that Congress in imposing the moratorium reaffirmed that its sole intent in enacting the "same methodology requirement" had been to invalidate HHS's 1981 regulations "allowing the states to impose more restrictive [income and resource] standards and methodologies than under previous law * * * for determining eligibility of the medically needy." *See* H.R. Report NO. 861, 98th Cong. 2d Sess. 1366-67 (1984). The *Atkins* court has read such legislative history incorrectly as having application to other than income and resource standards (Petition, p A26).

not more than the Medicaid income level set by the state." 770 F2d at 326. The spend down, it was stated, is not part of that standard but is "the method by which a family that does not meet the standard can nonetheless bring its excess income down to the level required for inclusion in the Medicaid program (770 F2d at 326).

The court concluded:

> "While in one sense New York's six-month spend-down requirement may be a 'methodology,' Congress can hardly have regarded it as such for purposes of [section 1396a(a)(C)(i)(III)]: since the spend-down has no counterpart in the eligibility methodologies of the cash assistance programs, it would have been tautologous for Congress to direct that states calculate spend-downs using 'the same methodology' as they use in determining eligibility for those programs. Given the history showing that Congress was aiming its shafts in TEFRA at actions of the Secretary involving quite different matters, and indeed arguably was approving the Secretary's pre-OBRA regulation permitting a spend-down of up to six months (a regulation that had gone unchallenged for over 17 years), we cannot say that the Secretary's construction is untenable, although we recognize that a different one also might not be.
>
> "This conclusion is all that is required to sustain the Secretary's position that New York's six-month spend-down requirement. * * * is authorized by HHS's longstanding regulation * * * 42 C.F.R. §435.831 (1984)" (770 F2d at 327).

While the court did not do so, it could have cited this Court's opinions in *FEC v. Democrats Senatorial Campaign Committee,* 454 US 27, 39 (1981); *Udall v. Tallman,* 380 US 1, 16 (1964), and *Unemployment Comm. v. Aragon,* 329 US 143, 153 (1946), in support of this holding. See, also, *Connecticut Department of Income Maintenance v. Heckler,* 105 S.Ct. at 2215; *Costanzo v. Tillinghaust,* 287 US 341, 345 (1932); *Red Lion Broadcasting Co. v. FCC,* 395 US 367, 381 (1969).

The "same methodology" provisions of section 1397a(a)(10)(C)(i)(III), the comparability provisions of subdivision 17 of that section, and the spend down-flexibility provisions of subdivision 17 are not only all part of the Social Security Act. They are part of the same section and the same subdivision i.e., 42 USC §1396a(a), the purpose of which is to define what a State Medicaid plan must provide. The Seeretary's construction of that subdivision, supported by the *DeJesus* court, as well as by the decision of the United States Court of Appeals for the First Circuit in *Hogan v. Heckler,* has been consistent and reasonable. The Secretary did not exceed his statutory authority in promulgating 42 CFR §435.831, nor is that regulation arbitrary or capricious. *Batterton v. Francis; Schweiker v. Gray Panthers.* It plainly and properly permits what Massachusetts and New York have done.

CONCLUSION.

The order of the Massachusetts Supreme Judicial Court should be reversed.

Dated: Albany, New York
January 21, 1986

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42 CFR

§435.831 Income eligibility.

The agency must determine income eligibility of medically needy individuals in accordance with this section. The agency must use a prospective period of not more than 6 months to compute income.

(a) *Determining countable income.* The agency must deduct the following amounts from income to determine the individual's countable income.

(1) For individuals under age 21 and caretaker relatives, the agency must deduct amounts that would be deducted in determining eligibility under the State's AFDC plan.

(2) For aged, blind, or disabled individuals in States covering all SSI recipients, the agency must deduct amounts that would be deducted in determining eligibility under SSI. However, the agency must also deduct the highest amounts from income that would be deducted in determining eligibility for optional State supplements if these supplements are paid to all individuals who are receiving SSI or would be eligible for SSI except for their income.

(3) For aged, blind or disabled individuals in States using income requirements more restrictive than SSI, the agency must deduct amounts that are no more restrictive than those used under the Medicaid plan on January 1, 1972 and no more liberal than those deducted in determining eligibility under SSI or an optional State supplement. However, the amounts must be at least the same as those that would be deducted in determining eligibility, under §435.121, of the categorically needy.

(b) *Eligibility based on countable income.* If countable income determined under paragraph (a) of this section is equal to or less than the applicable income standard under §435.814, the individual or family is eligible for Medicaid.

(c) *Deduction of incurred medical expenses.* (1) If countable income exceeds the income standard, the agency must deduct from income, in the following order, incurred medical expenses that are not subject to payment by a third party:

(i) Medicare and other health insurance premiums, deductibles, or coinsurance charges, incurred by the individual or family or financially responsible relatives, including enrollment fees, copayments, or deductibles imposed under §447.51 or §447.53 of this subchapter.

(ii) Expenses incurred by the individual or family or financially responsible relatives for necessary medical and remedial services that are recognized under State law but not included in the plan.

(iii) Expenses incurred by the individual or family or by financially responsible relatives for necessary medical and remedial services that are included in the plan.

(2) The agency may set reasonable limits on the amounts of incurred medical expenses to be deducted from income under paragraphs (c) (1) (i) and (ii) of this section.

(d) *Eligibility based on incurred medical expenses.* Once deduction of incurred medical expenses reduces income to the income standard, the individual is eligible for Medicaid.

42 USC

§1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must—

* * *

(10) provide—

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5) and (17) of section 1396d(a) of this title, to—

(i) all individuals—

(I) who are receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI of this chapter, or part A or part E of subchapter IV of this chapter (including individuals eligible under this subchapter by reason of section 602(a)(37) or 606(h) of this title, or considered by the State to be receiving such aid as authorized under section 614(g) of this title),

(II) with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, or

(III) who are qualified pregnant women or children as defined in section 1396d(n) of this title;

(ii) at the option of the State, to any group or groups of individuals described in section 1396d(a) of this title (or, in the case of individuals described in section 1396d(a)(i) of this title, to any reasonable categories of such individuals) who are not individuals described in clause (i) of this subparagraph but—

(I) who meet the income and resources' requirements of the appropriate State plan described in clause (i) or the supplemental security income program (as the case may be).

(II) who would meet the income and resources requirements of the appropriate State plan described in clause (i) if their work-related child care costs were paid from their earnings rather than by a State agency as a service expenditure.

(III) who would be eligible to receive aid under the appropriate State plan described in clause (i) if coverage under such plan was as broad as allowed under Federal law.

(IV) with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, aid or assistance under the appropriate State plan described in clause (i), supplemental security income benefits under subchapter XVI of this chapter, or a State supplementary payment;

(V) who are in a medical institution, who meet the resource requirements of the appropriate State plan described in clause (i) or the supplemental

security income program, and whose income does not exceed a separate income standard established by the State which is consistent with the limit established under section 1396b(f)(4) (C) of this title, or

(VI) who would be eligible under the State plan under this title if they were in a medical institution, with respect to whom there has been a determination that but for the provision of home or community-based services described in section 1396n(c) of this title they would require the level of care provided in a hospital, skilled nursing facility or intermediate care facility the cost of which could be reimbursed under the State plan, and who will receive home or community-based services pursuant to a waiver granted by the Secretary under section 1396n(c) of this title;

(B) that the medical assistance made available to any individual described in subparagraph (A)—

(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A);

(C) that if medical assistance is included for any group of individuals described in section 1396d(a) of this title who are not described in subparagraph (A), then—

(i) the plan must include a description of (I) the criteria for determining eligibility of individuals in the group for such medical assistance, (II) the amount, duration, and scope of medical assistance made available to individuals in the group, and (III) the single standard to be employed in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligiblity, which shall be the same methodology which would be employed under the supplemental security income program in the case of groups consisting of aged, blind, or disabled individuals in a State in which such program is in effect, and which shall be the same methodology which would be employed under the appropriate State plan (described in subparagraph (A)(i)) to which such group is most closely categorically related in the case of other groups:

(ii) the plan must make available medical assistance—

(I) to individuals under the age of 18 who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A)(i), and

(II) to pregnant women, during the course of their pregnancy, who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A);

(iii) such medical assistance must include (I) with respect to children under 18 and individuals entitled to institutional services, ambulatory services, and (II) with respect to pregnant women, prenatal care and delivery services; and

(iv) if such medical assistance includes services in institutions for mental diseases or intermediate care facility services for the mentally retarded (or both) for any such group, it also must include for all groups covered at least the care and services listed in paragraphs (1) through (5) and (17) of section 1396d(a) of this title or the care and services listed in any 7 of the paragraphs numbered (1) through (17) of such section; and

(D) for the inclusion of home health services for any individual who, under the State plan, is entitled to skilled nursing facility services;

except that (I) the making available of the services described in paragraph (4), (14), or (16) of section 1396d(a) of this title to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages. (II) the making available of supplementary medical insurance benefits under part B of subchapter XVIII of this chapter to individuals eligible therefor (either pursuant to an agreement entered into under section 1395v of this title or by reason of the payment of premiums under such subchapter by the State agency on behalf of such individuals), or provision for meeting part or all of the cost of deductibles, cost sharing, or similar charges under part B of subchapter XVIII of this chapter for individuals eligible for benefits under such part, shall not, by reason of this paragraph (10), require the making available of any such benefits, or the making available of services of the same amount, duration, and scope, to any other individuals. (III) the making available of medical assistance equal in amount, duration, and scope to the medical assistance

made available to individuals described in clause (A) to any classification of individuals approved by the Secretary with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment shall not, by reason by this paragraph (10), require the making available of any such assistance, or the making available of such assistance of the same amount, duration, and scope, to any other individuals not described in clause (A) and (IV) the imposition of a deductible, cost sharing, or similar charge for any item or service furnished to an individual not eligible for the exemption under section 1396d(a)(2) or (b)(2) of this title shall not require the imposition of a deductible, cost sharing, or similar charge for the same item or service furnished to an individual who is eligible for such exemption:

* * *

42 USC §1396a(a)(10)(A)(i) is quoted as amended by the Deficit Reduction Act of 1984, Public Law 98-369, §§ 2361(a) and 2373(b)(2) (98 Stat 1104 and 1111) and by Public Law 98-378, §20(c) (98 Stat 1322).

* * *

(17) include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under sub-

chapter XVI of this chapter, based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, as determinined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or to have paid with respect to him supplemental security income benefits under subchapter XVI of this chapter) as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1382c of this title (with respect to States which are not eligible to participate in such program); and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums or otherwise) incurred for medical care or for any other type of remedial care recognized under State law;

Supreme Court, U.S.
FILED
MAR 3 1986
JOSEPH F. SPANIOL, JR.
CLERK

No. 85-632

In the Supreme Court

OF THE

United States

OCTOBER TERM, 1985

CHARLES ATKINS, COMMISSIONER OF THE MASSACHUSETTS DEPARTMENT OF PUBLIC WELFARE,
Petitioner,

v.

SANTOS RIVERA, et al.,
Respondents.

On Writ of Certiorari to the Supreme Judicial Court of Massachusetts

BRIEF FOR SUSAN REED AND WADIE REESE AS AMICI CURIAE IN SUPPORT OF RESPONDENTS

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51 Fed. Reg. 4653-54
(February 6, 1986) 17

INTEREST OF AMICI CURIAE

This case turns upon the meaning of §1902(a)(10)(c)(i)(III) of the Medicaid Act [42 U.S.C. §1396a(a)(10)(C)(i)(III)]. That provision, (hereinafter §(a)(10)(C)), requires that states which maintain optional Medicaid programs for the "medically needy"[1]/ include in their state plans a description of:

> the single standard to be employed in determining income and resource eligibility for all such [medically needy] groups, and the methodology to be employed in determining such eligibility, which shall be the same methodology which would be employed under the [SSI] program

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1/ The medically needy are aged or disabled individuals and families with children who would be eligible for SSI or AFDC cash benefits, respectively, but for the fact that their income or resources exceed the limits of the cash programs. 42 U.S.C. §1396a(a)(10)(C). States are required to provide Medicaid coverage to SSI and AFDC recipients, who are known as the "categorically needy." 42 U.S.C. §1396a(a)(10)(A).

> in the case of groups consisting of aged, blind, or disabled individuals ..., and which shall be the same methodology which would be employed under the appropriate State plan ... to which such group is most closely categorically related in the case of other groups.

Amici are intervenors in pending administrative hearings, described at pp. 4-8, infra, which the State of California requested pursuant to 42 U.S.C. §1316(a)(2),(b) and 45 C.F.R. §201.4. In those proceedings, California seeks to maintain Medicaid eligibility criteria for its aged and disabled medically needy which are less restrictive than those used in the related cash program -- there the SSI program.2/ Intervenors will contend

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2/ Section (a)(10)(C) links the Medicaid methodologies for the medically needy aged, blind and disabled to the SSI program, and those for families with children to the AFDC program. The analysis of its "same methodology" language is the same, no matter which group of medically needy recipients is involved.

that California's criteria are consistent with and authorized by §(a)(10)(C).

Respondents here maintain only that Massachusetts cannot maintain Medicaid criteria which are more restrictive than those used in the AFDC program. Nevertheless, both Petitioner and the United States seemingly ask this Court to assume, in passing, that more liberal criteria are prohibited. Pet. Br. at 10 n.9, 24, 34 n.25; Br. of United States at 5. If these two aspects of §(a)(10)(C) are not carefully distinguished, this Court's construction of §1902(a)(10)(C)'s "same methodology" language may affect the interests of amici, of other similarly situated residents of California, and of thousands of medically needy individuals in other states. Amici urge that the Court address only the issue before it,

leaving the question of more liberal criteria to another day.

Susan Reed

Amicus Susan Reed is an intervenor in a pending HHS reconsideration proceeding concerning California State Plan Amendment 85-24. California proposes to treat the income of an aged or disabled medically needy Medicaid recipient as unavailable to the extent that it is used to pay spousal or child support pursuant to court order or an agreement with a District Attorney.[3/]

3/ The State's Department of Health Services ("DHS") submitted its plan amendment to HHS after a state court invalidated a DHS regulation which treated income used by aged and disabled medically needy Medicaid recipients to comply with family support obligations as nevertheless available to meet their own needs. Gibbons v. Rank, CCH Medicare and Medicaid Guide ¶33995 (Alameda Cty. Super. Ct., 1984). Amicus was a plaintiff in that action.

The Acting Administrator of HHS' Health Care Financing Administration (HCFA) initially disapproved California's plan amendment on the ground that in the SSI program, income used to pay family support payments nonetheless must be considered available to meet the needs of an aged or disabled SSI recipient. According to the Administrator, §(a)(10)(C) prohibits the State from maintaining a Medicaid methodology for determining income eligibility which is more liberal than that used for determining SSI eligibility. 51 Fed. Reg. 3512 (January 28, 1986).

Amicus' husband, Robert Reed, has been semi-comotose since he was in an accident in 1975. He needs skilled nursing care, which can only be provided in a long term care facility. Mr. Reed is under a court order to pay child support

of $800 per month for the care of his two children. If the Secretary of HHS finally disapproves California's state plan amendment, and if that determination is upheld in the Court of Appeals, to which the State may appeal directly, (42 U.S.C. §1316(a)(3)), Susan Reed, as conservator of her husband, will risk having her husband evicted from the nursing home for failure to pay his share of his medical bills. Alternatively, she will have to forego court-ordered child support payments, thereby depriving her children of necessities.

Wadie Reese

Wadie Reese is a plaintiff in Reese v. Kizer, No. H-104037-3 (Alameda Cty. Super. Ct.). That case seeks to enforce Cal. Welfare & Institutions Code §14005.16(a), which provides that, for Medicaid eligibility purposes, a non-

institutionalized spouse's community property interest in her medically needy institutionalized spouse's income is not available to meet his needs. The Director of California's Department of Health Services refused to implement the state law after HHS advised the State that the statute violates §(a)(10)(C), since community property rules are not applied in the SSI program.

On April 19, 1985, the Superior Court entered a preliminary injunction requiring, on state law grounds, that DHS implement the statute. Pursuant to that injunction, Mrs. Reese, who is entirely dependent upon her husband for support, receives $630 per month. But for the injunction, she would receive an allowance of only $509, an amount insufficient to meet her basic needs.

California State Plan Amendment 85-5

reflects the terms of the Reese injunction. The Acting Administrator of HCFA initially disapproved the plan amendment because it assertedly conflicts with §(a)(10)(C). 51 Fed. Reg. 3513 (January 28, 1986).4/ California has requested a reconsideration hearing, in which amicus Reese is an intervenor.

SUMMARY OF ARGUMENT

Relying upon the legislative history of TEFRA and express congressional authorization contained in the Deficit

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4/ A related issue is pending in Purser v. Rahm, 104 Wn.2d 159, 702 P.2d 1196 (1985), petition for cert. filed, 54 U.S.L.W. 331 (U.S. Nov. 5, 1985) (No. 85-663). As a result of the Purser decision, Washington submitted a state plan amendment which was disapproved. 50 Fed. Reg. 20,857 (May 20, 1985). After a reconsideration hearing, the Secretary of HHS issued a final decision on February 5, 1986, disapproving the amendment. The State may appeal to the Ninth Circuit within sixty (60) days. 42 U.S.C. §1316(a)(3).

Reduction Act of 1984, many states have adopted medically needy methodologies and standards more liberal than those used in the cash assistance programs. This Court need not and should not decide whether the Medicaid Act permits such methodologies and standards, since respondents contend only that Massachusetts may not maintain a methodology which is more restrictive than that used in the State's AFDC program.

ARGUMENT

THE COURT SHOULD NOT INTIMATE THAT TEFRA REQUIRES STATES TO USE MEDICALLY NEEDY METHODOLOGIES IDENTICAL TO THOSE USED IN THE CASH ASSISTANCE PROGRAMS, SINCE CONGRESS HAS CLEARLY AUTHORIZED MORE LIBERAL METHODOLOGIES

Section 1902(a)(10)(C) requires that states use the "same" methodologies in their medically needy programs as are used in the cash assistance programs. The history of this provision reveals that, when Congress enacted the "same

methodology" language in the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA"), Pub. L. No. 97-248, §137(a)(8), 96 Stat. 324, 378, it clearly did not intend to prohibit states from adopting more generous methodologies better suited than cash assistance criteria to the needs of the medically needy, a group which tends to suffer from serious and debilitating illnesses frequently necessitating hospitalization or long term skilled nursing care. See generally Wulsin, Adopting A Medically Needy Program, 18 Clearinghouse Rev. 841, 847-48 (1984).

Prior to 1981, §1902(a)(10)(C) required that eligibility standards for the medically needy be "comparable" to those used for the categorically needy. Both HHS and the courts understood this language to mean that states were prohibited from using medically needy criteria

which were more restrictive than those used in the cash assistance programs, but were permitted to use more liberal standards. See, e.g., 42 C.F.R. §§ 435.401(c),5/ 435.812, 435.840 (1979). See generally, Caldwell v. Blum, 621 F.2d 491, 495 (2d Cir. 1980); Calkins v. Blum, 511 F.Supp. 1073, 1091 (N.D.N.Y. 1981), aff'd, 675 F.2d 44 (2d Cir. 1982); 42 Fed. Reg. 2684, 2685 (January 13, 1977) ("[W]hile a state might use more generous maintenance amounts in determining financial eligibility (i.e., medically needy levels ..., disregards or asset exemptions) all other SSI eligibility criteria are to be used.") See also H.R. Rep. No. 861, 98th Cong. 2d Sess. 1366-1367 (1984), reprinted in 1984 U.S. Code Cong. & Admin. News 2054.

5/ This regulation has not been repealed or amended.

In 1981, Congress amended §(a)(10)(C) to give states additional flexibility in designing their medically needy programs. Pub. L. 97-35, §2171(a)(3), 95 Stat. 357, 807. During debate, the managers of the bill made clear that Congress did not intend to permit any change in existing comparability rules. 127 Cong. Rec. 18,957 (middle column) (July 31, 1981) (Rep. Dingell); Id. at 18,948 (middle column) (Rep. Waxman). See generally DeJesus v. Perales, 770 F.2d 316, 325 (2d Cir. 1985), petition for cert. docketed, (February 7, 1986) (No. 85-6337). Nevertheless, in September, 1981 HHS issued regulations which for the first time permitted more restrictive methodologies. 46 Fed. Reg. 47976, 47980 (Sept. 30, 1981).

When it enacted TEFRA, Congress carefully explained that the purpose of

§(a)(10)(C)'s "single standard" and "same methodology" language was to restore the pre-1981 comparability rules. H.R. Rep. No. 757, Pt. 1, 97th Cong. 2d Sess. 13 (1982). Congress thereby reaffirmed that states were prohibited from imposing "more restrictive standards and methodologies than under previous law." H.R. Rep. No. 861, supra, at 1366-67 (emphasis added). See, DeJesus v. Perales, supra, at 326 n.12.

Despite Congress' clear explanation of its intent, the Secretary rigidly construed the new language of §(a)(10)(C). She took the position that, whereas previously states could deviate from cash assistance eligibility criteria in order to adopt more liberal standards and methodologies, after TEFRA they were required to use the identical methodologies for determining income and resource

eligibility as are applied in the AFDC or SSI programs.

As Congress subsequently found, "The Department's overly restrictive interpretation has posed grave administrative problems for the States and threatens to cause great hardships for applicants and beneficiaries." H.R. Rep. No. 861, supra, at 1367. For example, HHS has refused to permit states to grant mid-month Medicaid eligibility to medically needy applicants once they spend their resources down to the applicable standard, but rather has required states to delay eligibility until the first of the following month, as is done in the SSI program. Id. See also, 51 Fed. Reg. 1301 (January 10, 1986) (despite Congress' intent to remedy this problem, HCFA disapproves North Carolina's proposal to provide Medicaid coverage for the month in which resources are reduced

to the eligibility level). As a result, medically needy institutionalized Medicaid recipients faced with the high cost of nursing home care are forced to deplete their exempt resources.

Congress acted swiftly to pretermit the Secretary's overly rigid interpretation of the TEFRA language. In §2373(c)(1) of the Deficit Reduction Act of 1984 ("DRA"), Pub. L. 98-369, 98 Stat. 494, 1112, Congress stayed the Secretary's literal enforcement of §(a)(10)(C)'s "same methodology" requirement pending a "moratorium" period of at least thirty (30) months. During that time, the conference committee directed that, "States may use less restrictive standards and methodologies in their noncash programs, although they are still foreclosed from being more restrictive than the relevant cash assistance programs." H.R. Rep. No. 861,

supra, at 1368.

Despite the clarity of the DRA moratorium provision, the Secretary has nevertheless refused to approve state plan amendments submitted after enactment of the DRA which adopt standards and methodologies more liberal than those used in the cash programs. Rather, the Secretary has taken the position that the moratorium applies only to state plans existing as of July 18, 1984, the effective date of the DRA. He maintains that policy to this day, despite the fact that both Houses of Congress have expressly disapproved that interpretation. H.R. 1868, §9; H.R. Rep. 99-80, Pt. 2, 99th Cong. 1st Sess. 27-28 (1985); S. 1730, §759C; S. Rep. 99-146, 99th Cong.

1st Sess. 319-321 (1985).6/

The California and North Carolina state plan amendments described above have fallen prey to the Secretary's persistent refusal to abide by Congress' intent. See pp. 4-8, 14, supra. Nor are these the only states to be frustrated in their efforts to meet the needs of the medically needy. See, e.g., 51 Fed. Reg. 4653-54 (February 6, 1986) (disapproving South Carolina amendment proposing to use a single automobile resource exclusion for all medically needy, because the exclusion, derived from the SSI program, is more liberal than that used in the AFDC program); 50 Fed. Reg. 48,642 (November

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6/ The relevant language of the House and Senate reports is set out in the Appendix. The Senate provision is incorporated in the pending Consolidated Omnibus Budget Reconciliation Act of 1985, H.R. 3128, §9521.

28, 1985) (disapproving Virginia State Plan Amendment 84-13, proposing to use uniform, SSI-related criteria for all medically needy recipients, including AFDC-linked families); 50 Fed. Reg. 32,642 (August 14, 1985) (disapproving Minnesota amendment proposing to use a number of income and resource methodologies more liberal than those used in the related cash assistance programs).

The courts have only recently begun to consider the meaning of §(a)(10)(C) in light of the DRA moratorium provision. See, e.g., Cubanski v. Heckler, No. 85-7123 (9th Cir. 2/7/86) (available February 28, 1986 on LEXIS, Genfed library, U.S. App. file) (allowing states to maintain an income standard for adult couples less restrictive than that required for a family of a parent and child). Compare, Camacho v. Perales, No. 85-7139 (2d Cir.

1/24/86), petition for reh'g pending (available February 28, 1986 on LEXIS, Genfed library, U.S.App. file) (refusing to permit the State to use a methodology which is, in its totality, less restrictive than that used in the SSI program); Rivera v. Commissioner of Public Welfare, 395 Mass. 189, 479 N.E.2d 639 (1985), cert. granted on other grounds, 54 U.S.L.W. 3392 (U.S. Dec. 10, 1985) (No. 85-632) (holding that state statute which applied earned income disregards more liberal than those used in the AFDC program violates (a)(10)(C)).7/ Given the

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7/ In a footnote, the Massachusetts Supreme Judicial Court read the DRA moratorium to prevent HHS from penalizing a state for refusing to use medically needy eligibility standards which are more restrictive than the related cash assistance programs. The Court found it "unnecessary to examine the moratorium to determine to what extent the State may use a less restrictive standard." 479 N.E.2d at 643 n. 7. This aside simply stands the DRA moratorium on its head, as Petitioner notes. (Pet. Br. at 48 n.31).

numerous pending reconsideration hearings involving the meaning of §(a)(10)(C) and of the moratorium, it can be expected that there will soon be a developing body of case law on the subject. Until this Court has before it a case or controversy to "assure that concrete adverseness which sharpens the presentation of [such] issues ...," Baker v. Carr, 369 U.S. 186, 204 (1962), it should neither decide whether §(a)(10)(C) permits more liberal medically needy methodologies than those used in the cash assistance programs, nor intimate that identical methodologies are required.

CONCLUSION

Since 1982, Congress has expressed its intent in words of exceptional clarity. States are prohibited from using more restrictive medically needy methodologies than are used in the cash assistance programs, but are free to use

more liberal criteria. Nevertheless, in their briefs, Petitioner and the United States invite the Court to assume that Massachusetts' medically needy methodologies must be identical to those used in the related AFDC program. The Court should decline unnecessarily to tread upon waters which, at this date, are so turbulent, and should make clear that it does not decide that question here.

Respectfully submitted,

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APPENDIX

S. Rep. 99-146, 99th Cong.
1st Sess. 319-321 (1985)

Clarification of Medicaid Moratorium Under DEFRA

Current Law - Under the "Omnibus Budget Reconciliation Act of 1981" States were given certain flexibility in structuring their medically needy programs. They were allowed to limit coverage to certain categories of persons and to vary the scope of services offered. Changes were not made in the financial eligibility requirements. However, implementing regulations made changes in the pre-OBRA financial eligibility rules and allowed the States to impose more restrictive standards and methodologies. The "Tax Equity and Fiscal Responsibility Act of 1982" (TEFRA) amended the Medicaid statute to clarify that Congress did not intend to change the policies governing

income and resource standards and methodologies for determining eligbility of the medically needy from those in effect prior to OBRA. The TEFRA provision specified that the methodology to be used in determining income and resource eligibility for the medically needy must be the same methodology used under the relevant cash assistance' program. However, a strict interpretation of this provision by the Department led to unintended and in certain cases, undesirable consequences. The "Deficit Reduction Act of 1984" (DEFRA) established a moratorium period during which the Secretary is directed not to take any compliance, disallowance penalty or other regulatory action against a State because a State in determining eligibility for noncash Medicaid recipients is using an income or resource standard or methodology

that is less restrictive than the applicable cash assistance standard or methodology. The Secretary was directed to report to Congress within 12 months of enactment on the impact on States and recipients of applying income and resource standards and methodologies under the cash assistance programs to noncash eligibles. The moratorium is to run from the date of enactment until 18 months after submission of the required report. DEFRA further specified that no provision of law could repeal or suspend the moratorium unless such provision specifically amended or repealed that provision.

In January, 1985, the Health Care Financing Administration issued a Medicaid Action Transmittal (85-1) to all State Medicaid agencies setting forth HCFA's interpretation of the moratorium provision of the Deficit Reduction Act. The

Transmittal concludes that the moratorium applies only where the "existing approved State plan" is or would be in violation of the requirement, as interpreted by HCFA, that the States apply the same methodology or standards to their non-cash assistance Medicaid beneficiaries as they apply to their cash assistance recipients. The Transmittal concludes, "Since the moratorium applies only where the existing approved State plan is or would be in violation of the provisions of section 1902(a)(10)(C)(i)(III) and since Medicaid eligibility quality control (MEQC) reviews are conducted against the approved State plan, the moratorium will have no effect on MEQC reviews or error rates for past or future periods."

This interpretation is inconsistent with the intent of Congress.

. . .

Explanation of provision. -- The provision would clarify that the moratorium on the Secretary's sanction activities applies to State Medicaid plans, whether or not approved, as well as the operation or administration of a Medicaid program by a State agency pursuant to that State plan. It also applies to any amendments to, or other changes in, a State plan, regardless of when the amendment or other change came to the Secretary's attention, and regardless of whether the Secretary has approved, disapproved, acted upon, or not acted upon the amendment or change. It applies to all States, including those States operating plans pursuant to section 1902(f) of the Social Security Act (relating to special eligibility rules for aged, blind, and disabled individuals receiving Supplemental Security Income).

It applies to Medicaid eligibility and quality control reviews and error rates for past and future periods.

. . .

Effective date. -- Effective as if included in the original DEFRA provision.

H.R. Rep. 99-80, Pt. 2 at 27-28,
99th Cong. 1st Sess. (1985)

Clarification of Medicaid Moratorium Provisions of the Deficit Reduction Act of 1984

The Committee bill clarifies that the current moratorium on the Secretary's imposition of any fiscal or other penalties on State Medicaid programs applies to State Medicaid plans, and State Medicaid program operations, whether approved or not, in all States. The content and reasoning of the Medicaid Action Transmittal No. 85-1, issued by the Health Care Financing Administration in January, 1985, in an apparent effort to nullify the moratorium, are specifically rejected.

Section 2373(c) of the Deficit Reduction Act of 1984, P.L. 98-369, prohibits the Secretary of Health and

Human Services from taking any compliance, disallowance, penalty, or other regulatory action against a State because the State uses less restrictive standards or methodologies in determining the eligibility of Medicaid beneficiaries who do not receive cash assistance than it uses for those who do. The prohibition applies during a moratorium period that began on enactment of P.L. 98-369 (July 18, 1984) and will end 18 months after the Secretary submits to Congress her recommendations on the application of cash assistance eligibility standards and methodologies to the "medically needy" and other non-cash Medicaid eligibles.

In January, 1985, the Health Care Financing Administration issued a Medicaid Action Transmittal (85-1) to all State Medicaid agencies setting forth HCFA's interpretation of the moratorium provision

of the Deficit Reduction Act. The Transmittal concludes that the moratorium applies only where the "existing approved State plan" is or would be in violation of the requirement, as interpreted by HCFA, that the States apply the same methodology or standards to their non-cash assistance Medicaid beneficiaries as they apply to their cash assistance recipients. The Transmittal concludes, "Since the moratorium applies only where the existing approved State plan is or would be in violation of the provisions of section 1902(a)(10)(C)(i)(III) and since Medicaid eligibility quality control (MEQC) reviews are conducted against the approved State plan, the moratorium will have no effect on MEQC reviews or error rates for past or future periods."

This interpretation is completely erroneous and flatly inconsistent with the

intent of Congress. It finds no support whatsoever in the text of section 2373(c) of the Deficit Reduction Act itself, nor in the extensive Joint State of Managers of the Committee of Conference (H.Rep. 98-861, pp. 1366-1368), and the Committee is frankly at a loss to understand how HCFA could have so badly misread the provision. The Department's interpretation will lead to precisely the result that the moratorium was intended to avoid: grave administrative problems and serious fiscal difficulties for the States, and great hardship for Medicaid applicants and beneficiaries.

The Committee bill clarifies that the moratorium on the Secretary's sanction activities applies. It applies to State Medicaid plans, whether or not approved, as well as the operation or administration of a Medicaid program by a State agency

pursuant to that State plan. It applies to any amendments to, or other changes in, a State plan, regardless of when the amendment or other change came to the Secretary's attention, and regardless of whether the Secretary has approved, disapproved, acted upon, or not acted upon the amendment or change. It applies to all States, including those States operating plans pursuant to section 1902(f) of the Social Security Act (relating to special eligibility rules for aged, blind, and disabled individuals receiving Supplemental Security Income). It applies to Medicaid eligibility and quality control reviews and error rates for past and future periods. The moratorium applies.

The Committee expects that the Secretary will, immediately upon enactment

of this provision, notify the State Medicaid agencies that Medicaid Action Transmittal 85-1 is null and void and that a moratorium on compliance, disallowance, penalty, and other regulatory actions is in effect as provided by section 2373(c) of the Deficit Reduction Act of 1984, as amended by the Committee bill.

(8)

No. 85-632

Supreme Court, U.S.
FILED
MAR 5 1986
JOSEPH F. SPANIOL, JR.
CLERK

IN THE
SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1985

CHARLES ATKINS, Commissioner
of the Massachusetts
Department of Public Welfare,

Petitioner,

v.

SANTOS RIVERA, et al.,

Respondents.

ON WRIT OF CERTIORARI TO THE SUPREME
JUDICIAL COURT OF MASSACHUSETTS

BRIEF AMICI CURIAE OF THE GRAY PANTHERS ADVOCACY COMMITTEE, EVELYN ALLEN, AND KATHLEEN IGNOTZ IN SUPPORT OF RESPONDENTS' POSITION

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EDITOR'S NOTE

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No. 85-632

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1985

CHARLES ATKINS, Commissioner
of the Massachusetts
Department of Public Welfare,
Petitioner,

v.

SANTOS RIVERA, Madeline McKenna,
and all others similarly situated,

Respondents.

BRIEF AMICI CURIAE ON BEHALF OF THE GRAY PANTHERS ADVOCACY COMMITTEE, EVELYN ALLEN, AND KATHLEEN IGNOTZ

INTERESTS OF AMICI CURIAE

The Gray Panthers Advocacy Committee, Evelyn Allen and Kathleen Ignotz are amici curiae in support of respondents

Rivera and McKenna and the class of Medicaid recipients they represent in this case.

The Gray Panthers Advocacy Committee is a committee of the Gray Panthers, a national organization comprised of 40,000 individuals who reside throughout the United States. "[D]edicated to helping the Nation's elderly," Schweiker v. Gray Panthers, 453 U.S. 34, 40 (1981), its members seek to reform and improve various laws and institutions which affect the lives of America's elderly, many of whom are Medicaid recipients. The Advocacy Committee itself has 30 to 40 low-income members who, from time to time, need Medicaid benefits and who suffer variously from lengthy spenddown periods in their different states.

Evelyn Allen is a sixty-one-year-old disabled woman residing in Bridgton, Maine, who lives on very modest Social Security and alimony payments. Ms. Allen is sometimes forced to forego needed medical attention for her emphysema during the period when she must reach a $900 spenddown which Maine requires for her to be eligible for Medicaid. Ms. Allen successfully challenged Maine's six-month Medicaid spenddown rule (Allen v. Petit, Civ. No. 85-0025P (D.Me. June 3, 1985)), only to have her victory crumble when the First Circuit ruled in Hogan v. Heckler, 769 F.2d 886 (1st Cir., 1985), petition for certiorari docketed No. 85-6386 (U.S. Feb. 14, 1986). If the Court in this case holds in respondents' favor, Ms. Allen stands to gain the reinstatement of her earlier success and,

more importantly, to achieve much-needed access to necessary medical care for her respiratory illness.

Kathleen Ignotz, a resident of Wheeling, West Virginia, suffers from chronic asthma and depends on consistent administration of steroids for successful treatment. Despite Ms. Ignotz' meager income of Social Security benefits and part-time wages, West Virginia's use of a six-month spenddown has resulted in her having to spend down amounts up to $876 before she could qualify for Medicaid. Because of the State's six-month spenddown period, Ms. Ignotz was left with a hospital bill in excess of $700 in 1985 -- a bill which would have totaled $133 if the State employed a one-month spenddown. Because of these inequities, Ms. Ignotz was prepared to sue West

Virginia to invalidate its six-month spenddown rule. However, the advent of the First and Second Circuit rulings in Hogan v. Heckler, supra, and DeJesus v. Perales, 770 F.2d 316 (2d Cir. 1985), petition for certiorari docketed No. 85-6337 (U.S. Feb. 7, 1986) deterred her from doing so. If the Court in this case affirms the decision below invalidating a six-month spenddown, Ms. Ignotz' ability to receive Medicaid coverage in the future will improve substantially.

SUMMARY OF ARGUMENT

Amici defer to Respondents' Brief for full argument of the legal issues in this case. Amici focus their Brief, instead, on three directly relevant aspects of this case:

1. The administrative rationality and workability of a one-month spenddown rule -- as demonstrated by the states which employ such a spenddown.

2. The adverse effect of a six-month spenddown on medically needy applicants and/or recipients -- as demonstrated a.) by reviewing he circumstances of several of the individual plaintiffs in cases similar to this action, and b.) by illustrating how the six month spenddown fails to target many of the neediest applicants.

3. The six-month spenddown's exacerbation of the presently increasing difficulty that the poor have in getting access to health care.

ARGUMENT

I. A One-Month Spenddown Is Administratively Simple In States Now Employing It.

Amici believe that there are a total of six states that either use a one-month spenddown period or allow recipients to choose a spenddown period varying in length from one to six months. They include large and populous states such as California and Illinois, as well as less populous states such as Hawaii, North Dakota, Utah, and South Carolina. In addition, New York allows a one month spenddown for ambulatory services but requires a six month spenddown for hospital care. See DeJesus v. Perales, 770 F.2d 316 (2d Cir. 1985). A brief description of the administration of the one-month spenddown in several of these states supports the conclusion that such a rule is not administratively burdensome.

California. California has the highest number of Medicaid recipients of any state in the nation, yet, it has almost exclusively used a one-month spenddown rule since 1976.[1] Only during a brief period of about fifteen months in 1981-82, did California use a longer three-month spenddown period.[2] California changed its spenddown period back to one month in 1982.[3] California's fiscal concerns with the one-month spenddown period could not have

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1 See, Act of July 4, 1976, ch. 126, §11, 1976 Cal. Stats. (enacting Cal. Welf. & Inst. Code §14005.9 (1976)); see also current Cal. Welf. & Inst. Code §14005.9(a).

2 Act of June 28, 1981, ch. 102, §100, 1981 Cal. Stats. (amending Cal. Welf. & Inst. Code §14005.9 (1981)).

3 Act of Sept. 30, 1982, ch. 1594, §20, 1982 Cal. Stats. (amending Cal. Welf. & Inst. Code §14005.9(a)).

been great; it reenacted the one-month limit at the same time as it thoroughly revamped its entire Medicaid system to include many severe cost-containment measures.[4]

The one-month spendown is easily administered in California. The medically nedy income level (MNIL) is a calculation based on an individual's or a family's non-medical needs for one month.[5] Upon application, each beneficiary's income is determined, and the appropriate MNIL is subtracted. The balance is his or her spenddown for that month.[6]

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[4]Act of June 30, 1982, ch. 328, 1982 Cal. Stats.; Act of Sept. 30, 1982, ch. 1594, 1982 Cal. Stats.; see also, "Health and Welfare; Medi-Cal Reform," 14 Pacific Law Journal 645 (1982).

[5]Cal. Welf. & Inst. Code §§14005.7 and 14005.12.

[6]Id.; 22 Cal. Admin. Code §50653.

The beneficiary receives a form shortly before a new month begins indicating the amount of the spenddown for the succeeding month.[7] The beneficiary carries this form to his or her physician, pharmacist or other medical services provider for documentation of bills paid or incurred up to the spenddown amount. Id. Once the spenddown amount is reached, the beneficiary submits the form to the local welfare office.[8] A Medicaid identification card is then mailed to the beneficiary within a matter of days, or if the beneficiary will need medical services before the mailed card arrives, he or she may obtain a temporary card from the welfare office.[9] Provision is

[7] 22 Cal. Admin. Code §50657(2)(A).

[8] 22 Cal. Admin. Code §50658(a).

[9] 22 Cal. Admin. Code §50658(c)(3)(d).

easily made for increased or decreased income and for over- or under-calculation of spenddown.[10] Beneficiaries are required to complete and return status reports concerning eligibility factors every three months;[11] but face-to-face interviews for the overall redetermination of eligibility only occur annually.[12]

Hawaii. Hawaii has chosen to use a one-month spenddown program since 1979, when beneficiaries complained that applicants with reoccurring monthly bills were experiencing difficulty becoming

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[10] 22 Cal. Admin. Code §§50653.5 and 50653.3.

[11] 22 Cal. Admin. Code §50191(a).

[12] 22 Cal. Admin. Code §50189(a).

eligible.[13] Hawaii's system is quite similar to that of California and is equally simple.

The MNIL is calculated on a one month basis.[14] An initial determination is made for each applicant as to his or her income eligibility and spenddown amount for each month. Once the beneficiary is notified of his or her spenddown amount, the beneficiary must submit to the local caseworker documentation of medical bills which have been incurred. The caseworker

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13 Telephone conversation, February 3, 1985, between Earl Motooka, Medicare Care Administrator, Department of Social Services & Housing, State of Hawaii, and J. Waxman, counsel for amici. The following description of the one-month spenddown program in Hawaii is based on this same conversation.

14 Hawaii Administrative Rules 17-744-71, Cost Sharing of Medical Care Costs.

has the authority to determine if the spenddown amount has been met for the month and to issue a Medicaid coupon which is valid for the remainder of the month. Each month, the beneficiary must accumulate documentation for incurred medical expenses and mail or take it to the caseworker who can issue coupons validating eligibility. Redeterminations of income and spenddown are made every six months for AFDC-related beneficiaries and every year for SSI beneficiaries. Applicants who receive an initial income determination but do not utilize the program for three consecutive months are terminated from the Medicaid rolls after proper notice. These individuals may seek redeterminations. The state does not view this system as administratively burdensome.

Illinois. Illinois also uses a MNIL based on one month's income. Under this plan,[15] applicants are given an initial determination of their income eligibility and monthly spenddown amount. The beneficiary is enrolled in the Medicaid program for a six-month period. The beneficiary has the responsibility of presenting documentation of incurred medical bills to the local caseworker who in turn determines eligibility. The caseworker verifies the documentation to determine if the bills equal the spenddown amount for one month. If so, the individual is granted eligibility for the remainder of the month.

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15 All elements of Illinois' plan described herein can be found in Illinois Department of Public Aid, Official Memorandum, issued May 15, 1984.

Additionally, if the beneficiary has bills which are greater than one month's spenddown, eligibility can be granted for extra months up to a total of six months. The number of months an applicant will be eligible depends on how many months of spenddown the documented medical bills cover. This system allows individuals the opportunity to obtain Medicaid coverage for up to five additional months beyond the initial month of eligibility.

Also, a beneficiary whose medical bills do not allow eligibility for all six months at the outset of the enrollment period, can submit additional bills within the six-month enrollment period to establish eligibility for additional months. At the end of the enrollment period, the beneficiary must

reapply to have the income eligibility and spenddown amount redetermined.

Although the caseworker in this system redetermines eligibility, he or she does not have the authority to issue a Medicaid card, as in Hawaii. Rather, the card is mailed to the recipient. A temporary card can be issued by the caseworker in certain circumstances, if requested. This system does not appear to create an unworkable administrative burden on the State.

In addition to its administrative viability, the use of a one-month spenddown does not necessarily threaten substantial increases in a state's Medicaid costs. As noted in Respondents' Opposition to Petition for Writ of Certiorari in this case, the Illinois

Medicaid budget for the AFDC-type medically needy did not increase significantly after the change from six-month to one-month budgeting required by the Court decision in Coleman v. Miller, No. 82-C-6259 (N.D.Ill. 1984). For the AFDC-related medically needy, the pre-Coleman Fiscal Year 1983 expenditures totaled $35,610,000, while for Fiscal Year 1985, the first full post-Coleman year, they totaled $36,501,000 -- a 2.5% increase.[16]

New York State, in its Amicus Brief in this case, estimates that implementation of a one month spenddown would result in an annual increase of

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16 Illinois Dept. of Public Aid Bureau of Management and Budget, "Medical Assistance Expenditures by Recipient Category FY 83 - FY 85" (as cited in Resp. Opp. to Pet. for Writ of Cert., at 6 n**.)

between $25 million and $30 million in costs relating to the State's existing case load. Amicus Brief of New York State at 2-3. It also estimates that a one-month spenddown would result in $78 million in additional expenditures for those not presently receiving medical assistance who would become Medicaid-eligible. Id. at 3. It is not clear whether this latter figure is an annual estimate, but assuming it is, and assuming the accuracy of these estimates, the state's worst case scenario calls for an annual increase of $108 million in medical assistance. While Amici by no means minimizes the importance of such an increase in expenditures, it is also important to put such increases in perspective. New York State's monthly medical assistance expenditures between

January and April, 1985 averaged $558,135,554 -- which implies a yearly total of almost $6.7 billion.[17] New York State's worst case predicted increase ($108 million) due to implementation of a one month spenddown, therefore, would constitute less than 1.7% of the State's probable Medicaid expenditure for FY 1985.

II. The Adverse Effect of a Six-Month Spenddown on Medically Needy Applicants/Recipients

A. Impact on Specific Individuals

In briefing in the lower courts, as well as briefing before this Court, Petitioners and Respondents aptly describe

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[17] Social Statistics, Monthly Summary, NYS Dept. of Social Services (9/11/85), p. 5, Table 5.

the workings of the Medicaid program and particularly the six month medically needy spenddown rule. In essence, the spenddown functions as a large deductible which the applicant must reach before he or she can receive Medicaid coverage. Amici believe it would be of value to this Court to have before it several varied examples of how the six-month spenddown impacts on individual Medicaid applicants -- examples which are readily available by reviewing the legal papers filed or decisions issued in other cases challenging the legality of a multi-month spenddown. A brief review of these cases, demonstrates that the six-month spenddown rule is one that wreaks havoc on medically needy individuals who frequently are more destitute, in terms of income available for health care, than their SSI and AFDC counterparts.

1. DON CARTER

Don Carter, the original plaintiff in Hogan v. Heckler, 597 F. Supp. 1106 (D. Mass., 1984), rev'd 769 F.2d 886 (1st Cir. 1985), petition for certiorari docketed No. 85-6386 (U.S. Feb. 14, 1986), a case involving SSI-related medically needy recipients, was injured by a six month spenddown. As explained by the District Court, at 597 F. Supp. 1109, Mr. Carter required the services of a personal care attendant (P.C.A.). He was a quadraplegic. Mr. Carter's income at the time this suit was filed totalled $743.76 per month. His P.C.A. services cost $875.27. Massachusetts calculated his "excess" income at $390.76 per month which meant that he had to incur about $2300 (six times his monthly excess) before he would be eligible for Medicaid. Ibid.

The District Court explained the effect of the State's policy on Mr. Carter:

> The Department's policy leaves Mr. Carter with two options. He can go begging for credit, trying to find a P.C.A. who is willing to work for months without getting paid. Mr. Carter was successful at this for awhile, but on the evening of November 1, 1982, his P.C.A., having gone unpaid for the three previous weeks, abandoned him. Mr. Carter's second option is to obtain higher medical care so that his "excess" income is spent down faster. This is what he ended up doing, although not by choice. After he was abandoned by his P.C.A., Mr. Carter was admitted for emergency care at the Western Massachusetts Hospital, where he remained for two months while his expenses caught up with the Department's projection of his income. The cost of the Department's six-month spenddown policy is measurable, therefore, both in terms of its potentially devastating impact on a human being, as well as by predictably higher

> expenditures of tax dollars for persons like Mr. Carter who are forced into high-cost institutional care.

597 F. Supp. at 1109.

Had the State employed a one-month spenddown for Mr. Carter, he could have remained home, retained the services of his P.C.A. and cost the State less for his coverage. Indeed, the District Court in Hogan pointed out that the Massachusetts' Department of Public Welfare, the very Petitioner in the case before this Court, recognized the problems of people like Mr. Carter and proposed a "targeted" one-month spenddown for the chronically ill and disabled. Ibid. The District Court noted that Petitioner submitted a request for Federal waiver to enable implementation of such a project. In doing so, Petitioner argued that a six month spenddown policy:

may well impose a hardship on many chronically ill and disabled individuals who require medical services on a daily, weekly or monthly basis in order to remain in the community. It may be extremely difficult or impossible for many of these individuals to both pay medical expenses sufficient to meet their six-month spenddown and maintain funds needed for food, shelter, and family support. They may instead find themselves having to choose between: foregoing necessary non-institutional medical care; submitting to costly and inappropriate hospitalization in order to incur medical expenses in excess of the six-month spenddown liability; or entering a nursing home in order to receive Medicaid coverage via a one-month spenddown. All of these options are ultimately more costly, both socially and economically. The individual is forced by financial imperatives either to physically suffer or to submit to unnecessarily intensive or restrictive inpatient care, the cost of which will likely be borne by Medicaid and Medicare.

Department of Public Welfare, Preventing Unnecessary Institutionalization of the Chronically Ill and Disabled: A One Month Spenddown Program, iv-v (July 5, 1984).

597 F. Supp. at 1109, n. 7.

2. GLADYS ALLISON

The plight of individuals subjected to the six-month spenddown provision also was clear to the Federal District Court in Brogan v. Miller, 537 F. Supp. 139 (N.D. Ill. 1982). In that case, the Court stated:

> There is no dispute that such a policy imposes a real and immediate hardship for members of the plaintiff class. The hardship arises from the requirement that a [medically needy] applicant must anticipate six months' worth of income to calculate his or her spenddown obligation but is not permitted to anticipate six months' worth of medical expenses to offset that income. A [medically needy] applicant who has only one month of income, for example,

> will be required to incur medical expenses to offset six months' worth of "excess" income before qualifying for Medicaid benefits. Under such a policy, individuals in plaintiffs' class will be presented with a "Hobson's choice" of delaying needed medical care in order to pay for other necessities as reflected in the state income eligibility standard or delaying the purchase of those necessities in order to pay for medical care and subsequently qualify for Medicaid.

Id., at 142. The Brogan Court then illustrated, in a footnote, the affect of the spenddown on Gladys Allison, of the plaintiffs in that action:

> The human cost of such a policy can be measured from the experience of Gladys Allison, a seventy-three year old [medically needy] recipient who suffers from chronic Lupus Erythematosus. Although Ms. Allison has available monthly income of only $312.20, [Illinois'] new policy will deny her Medicaid

benefits until she has incurred medical expenses totalling $295.20. In light of her present condition, her foreseeable medical expenses will total at least $175.00 per month. If she chooses to obtain all the medical care she requires, Ms. Allison will incur medical expenses totalling $175.00 in the first month and at least $120.20 in the second month before qualifying for Medicaid. Because of her precarious financial condition, Ms. Allison cannot obtain such medical care on credit. Accordingly, she will have only $137.20 left over to meet her living expenses in the first month and $192.00 in the second month. The State of Illinois has determined that at least $238 is needed each month to pay for the necessities of life (excluding medical care). Alternatively, if Ms. Allison chooses to obtain the necessities of life as defined by the state, she will have only $74.20 left over to pay for needed medical care in the first month this policy takes effect. This amount represents less than half of the total care she requires.

> This result is unconscionable. Lupus Erythematosus is a chronic disease which can be fatal unless the patient is carefully treated and monitored. Affidavit of Dr. Jerome Frankel, ¶3.

Id., at 142 n. 6.

3. GLORIA DEJESUS

The adverse impact of the six-month spenddown is by no means limited to SSI-related (elderly, blind, or disabled) medically needy recipients. In addition to the circumstances of the Respondents in this action, this Court might look to the appellee's circumstances in DeJesus v. Perales 770 F.2d 316 (2d Cir. 1985), petition for certiorari docketed No. 85-6337 (U.S. Feb. 7, 1986). In the Brief for Appellees submitted to the U.S. Court of Appeals for the Second Circuit, Gloria DeJesus, her husband and children,

are described as having, in 1984, a total monthly income of $729.77, consisting of Social Security disability and worker's compensation.[18] Ms. DeJesus and her children were calculated to have $151 per month in excess income in 1984 and, $154 in 1985. However, the State of New York requires a six month spenddown for inpatient hospital bills, consequently the DeJesus' spenddown for medical hospital coverage totaled $918 in January 1985.

This spenddown liability, nearly $200 more than their monthly income, posed a substantial barrier to health care access for Ms. DeJesus and her 7 year old daughter. Operations for both of these

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[18] The description of the DeJesus' circumstances is taken from the Brief for Appellees submitted in DeJesus v. Perales, supra.

individuals had to be cancelled at one hospital in 1984 when the DeJesus' were unable to pay a preadmission deposit of $906 (their six-month spenddown liability for inpatient hospital care in October 1984.) Similar cancellations occurred the following month at a second hospital. Only after Ms. DeJesus' attorneys advised the hospital of impending litigation on the six-month spenddown provision, was Ms. DeJesus able to have surgery performed in late November, 1984, upon payment of a $151 one-month spenddown.

B. A Six-Month Spenddown Is Not Responsive to the Neediest Applicants/Recipients

It is clear from the descriptions in the previous subsection that a six month spenddown results in a grave hardship to medically needy applicants. Petitioner's Brief and the Amicus Brief of the United

States both maintain, however, that six-month spenddown more accurately focuses scarce resources on those who have the greatest need for assistance because medical costs determined over a six-month period are a more persuasive indicia of hardship than medical costs incurred in any one month period. Petitioners Brief at 17, United States Amicus Brief at 16-17. Indeed, Petitioners take their argument to an extreme by maintaining that a one-month spenddown period will raise the flood gates through which will flow thousands of (presumably) middle income "medically needy" who have cancelled their health insurance, and timed all of their medical ills to occur in the same month, and are now poised to exploit the Medicaid medically needy program.

This latter proposition by Petitioners does not require extensive rebuttal. Amici would only point out that those who would attempt such an exploitation will be both surprised and chagrined when they learn of the resource limitations that are also part of the medically needy program. For example, in Massachusetts an individual who would make use of the medically needy spenddown program is allowed $2,000 in nonexempt assets ($3000 for a two person filing unit, and $100 more for each additional person beyond two).[19] Countable assets generally include cash, bank deposits, IRAS, Keough Plans, Pension Funds, stocks, bonds, money market funds, promissory notes, other financial

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19 Mass. Dept of Public Welf., 106 CMR, §505.110 (Rev. 11/85).

instruments, all but one (exempt) vehicle, cash surrender value of life insurance policies, and real estate other than principle place of residence.[20]

It is difficult to believe that many (if any) would cancel their health insurance,[21] engage in financial planning, and be prepared to dispose of their excess resources in order to qualify for the medically needy spenddown program. Moreover, even if an individual were bent on such a scheme he would risk

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20 Mass. Dept. of Public Welfare, 106 CMR §505.160.

21 Cancellation of health insurance would appear to be a particularly foolish action, since the cost of health care premiums can be applied to the spenddown. 42 C.F.R. §435.831(c)(1). Such health insurance would then be applied to cover the cost of medical bills prior to Medicaid's covering these costs. See, 42 C.F.R. §§433.135 et seq (Third Party Liability), portions of which are amended at 50 Fed. Reg. 46664-46666 (Nov. 12, 1985).

running afoul of Medicaid transfer of asset prohibitions common in many states which presume that certain assets transferred (at less than fair market value) by an individual prior to applying for Medicaid, were transferred for the purpose of qualifying for Medicaid.[22] Based on that presumption, these provisions prohibit Medicaid eligibility for extended periods of time. Indeed, if an individual of means was prepared to take such financially desperate steps to become eligible for the medically needy program, it is also possible that the length of the spenddown period, were it one month, three months, or six months, would not dissuade him.

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22 See 42 U.S.C. §1396p(c). The relevant regulations in Massachusetts can be found at Mass. Dept. of Public Welfare, 106 CMR §505.120.

In reality, of course, potential candidates for the medically needy program are not people of means but those living in varying degrees of poverty.[23] And within this framework, it is not at all clear that a six-month spenddown more precisely targets the poorest members of this population. For example, Petitioners argue that an applicant with $100 in excess monthly income, and medical expenses in excess of $600 over a six month period, is more needy than one such as Ms. Rivera with $314 in medical expenses over six months time even if the entire $314 is incurred in one month. Brief for the Petitioner at 17. This very example, to some degree, undercuts Petitioner's argument. The hypothetical applicant, in Petitioner's example, as

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[23] See Section III, infra, for further discussion on this point.

with the actual individuals described in the previous section of this Brief will not receive Medicaid assistance until $600 in medical bills has been incurred even if that total is not reached until the 4th, 5th or 6th month of the spenddown period. Alternatively, an individual with an unusually high medical bill in the first month of a six-month spenddown period will become eligible for Medicaid during that first month and remain on the program the remaining five months although medical costs during that period may be minimal. In other words, the advantage of a one month spenddown, is that it targets medically needy coverage for the period of time during which it is needed. In a month when medical bills are high, the applicant gets assistance in meeting those bills

for that month (but not for the remaining months); if medical bills are low that month, the spenddown is not reached, and no assistance is provided; if an individual has high medical bills each month, he or she receives aid each month.

The real strength of a one-month spenddown period in more effectively targeting the neediest, however, relates to the difficulty low-income people have in getting credit. An individual with a $600 six month spenddown may need to incur $600 in medical bills on credit before reaching his or her spenddown. That same individual with a $100 one-month spenddown need attain only $100 in credit before receiving medically needy assistance. As discussed in more detail in the following section, (and noted in several of the individual cases

illustrated in the previous subsection), the ability to get health care on credit is difficult for the poor. Many with a large six-month spenddown simply will not reach (and may eventually not even attempt to reach) their spenddown because of the amount of credit they would have to have extended to them. As a result, households that need to incur relatively low medical costs in order to receive preventative or ambulatory care, are less likely to reach a six month spenddown and are more apt to incur such a large spenddown only as a result of more costly hospital or emergency room treatment -- treatment that might have been avoided if they had not had to forego more timely preventative care due to their inability

to reach the spenddown.[24] Additionally, the longer spenddown period obviously presents a potentially life-threatening problem for those with chronic medical needs or conditions -- such as epileptics who need Dilantin, or diabetics who need insulin -- who are unable to get Medicaid because they cannot meet the large spenddown period quickly enough.

III. Cut Backs in Government Health Assistance Exacerbate the Adverse Effect of a Six-Month Spenddown.

Poor people always have had to struggle to receive proper health care. In the current atmosphere of cost

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24 One study has shown that, on average, 10% of unsuccessful spend down applicants are prevented from becoming eligible because of the cash flow problem of a six-month accounting period. Urban Systems Research and Engineering, Evaluation of Medicaid Spend Down at 63-64 and 157 (1976).

containment and competition, that struggle has intensified. Thus, between 1979 and 1984 those without any kind of health insurance have increased 22.3% from 28.7 to 35.1 million Americans.[25] There is substantial evidence that many of these people "fall through the cracks" of the health care system.[26] Those who are the most at risk are people who are too poor to buy health insurance and do not qualify for Medicaid and yet are sick. Poor people are not only more likely to not have insurance they are also more likely to be sick. Studies show that the poor are four times more

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25 U.S. Bureau of the Census, 1984 Current Population Survey.

26 Updated Report on Access to Health Care for American People, Special Report, No. One Princeton, N.J.: The Robert Wood Johnson Foundation, 1983.

likely to be in fair or poor health than non-poor people.[27]

Yet traditional sources of health care coverage have been reduced. According to a Robert Wood Johnson study the proportion of the poor and near poor covered by Medicaid has dropped from 63% in 1975 to 46% in 1985.[28] Indeed, only

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27 U.S. Department of H.H.S., P.H.S., N.C.H.S.R., Health Characteristics. According to Family & Personal Income, United States Data from the National Health Survey Series, 10, No. 147, January, 1985.

28 Sources: Unpublished data from Health Care Financing Administration, Office of Management and Budget, Institute for Research on Poverty, and the Brookings Institute. U.S. Department of Commerce, Bureau of the Census, Characteristics of the Population Below Poverty. Current Population Reports. Series P-60, No. 138, March 1983. Money Income and Poverty Status of Families and Persons in the United States, 1983. Current Population Reports. Series P-60, No. 145, August 1984.

39% of the elderly who live on incomes below the poverty line are covered by Medicaid.[29]

What, then, is happening to those who do not have health care? A 1982 study showed that one in six uninsured families reported increased difficulty in obtaining health care for financial reasons and one million families did not get health care for financial reasons.[30]

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29 Howell, Corder, and Dobson, "Out of Pocket Health Expenses For Medicaid Recipients & Low Income Persons 1980." National Medical Care Utilization & Expenditure Survey. Series B Descriptive Report #4. DHHS Pub. #85-20204. Office of Research & Demonstration, HCFA. Washington, D.C., U.S. Government Printing Office, August 1985.

30 Updated Report on Access to Health Care for American People, Special Report, No. One, Princeton, N.J.: The Robert Wood Johnson Foundation (1983).

The increase in the number of uninsured has put a tremendous strain on providers that traditionally serve the poor. Only ten percent of the nation's hospitals provide forty percent of all hospital care for the poor.[31] These hospitals have been under stress because of the increase in the number of uninsured and because other facilities are no longer doing their fair share of serving this population. Market pressures, such as negotiated lower rates to hospitals from insurance companies, and lower rates as a result of the prospective payment system utilized by the Medicare program have resulted in

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31 Feder, Judith et al., "Falling Through the Cracks: Poverty, Insurance Coverage & Hospital Care for the Poor 1980 & 1982." Milbank Memorial Fund Quarterly Health & Society, 62(4): 544-566, Fall 1984.

many hospitals turning away uninsured patients. The problem of "dumping" uninsured patients on to primarily public hospitals has reached epidemic proportions. In Chicago, Cook County General Hospital reported that transfers to its emergency room increased 1000%.[32] Dallas' Parkland Memorial Hospital[33] and D.C. General in Washington, D.C. each reported a 400% increase.[34] At Highland General Hospital in Alameda County, California, 85% of the people whose

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32 Bernard, "Patient Dumping: A Resident's Firsthand View" 34 The New Physician, 323 (October, 1985).

33 Statement of Ray Newman, Executive Vice President and Chief Operating Officer, Dallas County Hospital District before the Subcommittee on Health, Committee on Finance, U.S. Senate, Sept. 28, 1984, p. 22.

34 Engel, M., "Hospitals Refusing to Admit Poor: Patients Transferred to D.C. General," Washington Post (October 15, 1984).

health was jeopardized by a transfer, were uninsured.[35] Providers no longer want to serve uninsured people, nor will they if they can avoid doing so.

Respondents in this case, the individuals described in Section II-A of this Brief, and numerous medically needy applicants are representative of the uninsured who cannot get health care. They do not have the income or resources to purchase private insurance. They are totally dependent on what the state and federal government can provide to help them survive. As shown in Section II, a six month spenddown in the Medicaid program seriously hinders their ability to get the medical care they need. A six

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35 Annas, George J., "Your Money or Your Life: 'Dumping' Uninsured Patients from Hospital Emergency Wards," American Journal of Public Health," Vol. 76, No. 1, January, 1986.

month spenddown places them in the position of choosing between medical care or food and other necessities of life.

CONCLUSION

A one month spenddown will aid Respondents and those similarly situated in obtaining the only access to health care that is available to them. A one month spenddown is legally required, administratively workable, and essential to the health and well-being of the Respondents, amici Allen and Ignotz, and thousands of other poor people in this country. Amici urge this Court to find for Respondents in this case, to uphold the decision of the Supreme Judicial Court for the Commonwealth of Massachusetts, and to order the

Petitioner to implement a one month spenddown in Massachusetts' medically needy Medicaid program.